DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

July 27, 2010

Christine Neuhoff, System General Counsel
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

CMS Certification Number: 13-0006

Re: Plan of Correction Received

Dear Ms. Neuhoff:

The Centers for Medicare and Medicaid Services (CMS) has received St Lukes Regional Medical Center's voluntarily submitted plan of correction following the June 10, 2010, survey. CMS appreciates the time and effort of you and staff in developing and implementing the plan of correction. Please contact Kate Mitchell of my staff at (206) 615-2432 if you need further information.

Sincerely,

Steven Chickering
Western Consortium Survey and Certification Officer
Division of Survey and Certification

cc: Idaho Bureau of Facility Standards

COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@dhw.idaho.gov

June 30, 2010

Gary Fletcher
St. Luke's Regional Medical Center
190 East Bannock Street
Boise, Idaho 83712

RE: St. Luke's Regional Medical Center, provider #130006

Dear Mr. Fletcher:

This is to advise you of the findings of the complaint investigation survey, which was concluded at your facility on June 10, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

An acceptable plan of correction (PoC) contains the following elements:

- Action that will be taken to correct each specific deficiency cited;
- Description of how the actions will improve the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- Monitoring and tracking procedures to ensure the POC is effective in bringing the Hospital into compliance, and that the Hospital remains in compliance with the regulatory requirements;
- The plan must include the title of the person responsible for implementing the acceptable plan of correction; and
- The administrator's signature and the date signed on page 1 of the Form CMS-2567.

After you have completed your Plan of Correction, return the original to this office by **July 13, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

Sylvia Creswell for

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

Sylvia Creswell

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/srp
Enclosures

DEPARTMENT OF HEALTH & HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
Consortium For Quality Improvement and Survey & Certification Operations
Western Consortium – Division of Survey & Certification

IMPORTANT NOTICE – PLEASE READ CAREFULLY

June 29, 2010

Gary L. Fletcher, CEO
St. Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

CMS Certification Number: 13-0006

Re: Complaint survey 06/10/2010 and CoP not met
Deemed status removed and placed under State survey jurisdiction
Full health and life safety code survey to be conducted

Dear Mr. Fletcher:

To participate as a provider of services in the Medicare and Medicaid Programs, a hospital must meet all of the Conditions of Participation (CoP) established by the Secretary of Health and Human Services.

The Idaho Bureau of Facility Standards (State agency) completed a complaint investigation authorized by the Centers for Medicare & Medicaid Services (CMS) on June 10, 2010. Based on a review of the deficiencies identified during this investigation, we have determined that St. Lukes Regional Medical Center **is not in substantial compliance** with the Medicare hospital Condition of Participation – Patient Rights (42 Code of Federal Regulations (CFR) § 482.13).

Section 1865 of the Social Security Act (The Act) and pursuant regulations provide that a hospital accredited by The Joint Commission will be "deemed" to meet all Medicare health and safety requirements with the exception of those relating to utilization review. Section 1864 of The Act authorizes the Secretary of Health and Human Services to conduct a survey of an accredited hospital participating in Medicare if there is a substantial allegation of a serious deficiency which would, if found to be present, adversely affect the health and safety of patients. Therefore, as a result of the June 10, 2010, complaint survey findings, we are required following timely notification to the accrediting body, to place the hospital under Medicare State agency survey jurisdiction until the hospital is in compliance with all Conditions of Participation.

The deficiencies cited limit the capacity of St. Lukes Regional Medical Center to furnish services of an adequate level or quality. The deficiencies, which led to our decision, are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). It is not a requirement to submit a plan of correction; however, under federal disclosure rules, findings of the inspection, including the plan of correction submitted by the facility, become publicly disclosable within 90 days of completion.

You may therefore wish to submit your plans for correcting the deficiencies cited within 10 calendar days of receipt of this letter. An acceptable plan of correction contains the following elements:

- The plan for correcting each specific deficiency cited;
- The plan should address improving the processes that led to the deficiency cited;
- The plan must include the procedure for implementing the acceptable plan of correction for each deficiency cited;
- A completion date for correction of each deficiency cited must be included;
- All plans of correction must demonstrate how the hospital has incorporated its improvement actions into its Quality Assessment and Performance Improvement (QAPI) program, addressing improvements in its systems in order to prevent the likelihood of the deficient practice reoccurring. The plan must include the monitoring and tracking procedures to ensure the plan of correction is effective and that specific deficiencies cited remain corrected and/or in compliance with the regulatory requirements; and
- The plan must include the title of the person responsible for implementing the acceptable plan of correction.

Each deficiency should be corrected as soon as possible. Additionally, please sign and date page one where indicated prior to returning the CMS-2567 to our office. Please send the completed plan of correction to the address below, with a copy to the State agency:

CMS – Survey and Certification
Attention: Kate Mitchell
2201 Sixth Avenue, RX-48
Seattle, WA 98121
Fax: (206) 615-2088

Additionally, in accordance with § 1865(b) of The Act, the Idaho Bureau of Facility Standards, will conduct a full unannounced health and life safety code survey of your hospital to assess compliance with all the Medicare Conditions of Participation, within the next 60 days.

The recommendation that St. Lukes Regional Medical Center submit a plan to correct its Medicare deficiencies does not affect its accreditation, its Medicare payments, or its current status as a participating provider of hospital services in the Medicare program. When St. Lukes Regional Medical Center has been found to meet all the Medicare Conditions of Participation for hospitals, the State agency will discontinue its survey jurisdiction.

Under CMS regulations 42 CFR § 498.3(d), this notice of findings is an administrative action, not an initial determination by the Secretary, and therefore formal reconsideration and hearing procedures do not apply.

Copies of this letter are being provided to the State agency and The Joint Commission. You can also pursue any concerns you may have with The Joint Commission at any time.

If you have any questions, please contact Kate Mitchell of my staff at (206) 615-2432.

Sincerely,

Jeilyn McClain

for Steven Chickering
Western Consortium Survey and Certification
Division of Survey and Certification

Enclosure

cc: Debra Ransom, Idaho Bureau of Facility Standards
The Joint Commission

St Luke's™
Boise Regional
Medical Center
A St. Luke's Health System Hospital

190 East Bannock Street
Boise, Idaho 83712

stlukesonline.org

Gary L. Fletcher, CEO

June 28, 2010

Kate Mitchell
CMS Survey, Certification & Enforcement Branch
2201 Sixth Avenue, RX-48
Seattle, WA 98121

Re: Survey by Idaho Bureau of Facility Standards Ending June 10, 2010

Dear Ms. Mitchell:

The Idaho Bureau of Facility Standards ("BFS") indicated you will be the contact person with the Regional Office of CMS who will review the report that BFS prepared following the survey conducted at St. Luke's Regional Medical Center to investigate three patient grievances received by BFS. After our review of the preliminary findings, St. Luke's provided additional information to BFS for consideration in preparing their report submission for CMS. I understand BFS has forwarded our additional information to you. This information included: a letter from Gary Fletcher, CEO, dated June 14, 2010 with a binder of attachments (Memo from Chief Medical Officer to Chief Executive Officer Concerning Order for Versed Not Used as Chemical Restraint; Response to Preliminary Findings from the Bureau of Facility Standards Complaint Investigation, June 7-10, 2010; Revised Policy and Evidence of Education Provided to Records Release Personnel); and documentation of results of our investigation of an additional case identified to us by BFS surveyors after receiving the letter from Mr. Fletcher and the accompanying attachments. St. Luke's provided an additional communication to BFS on June 15, 2010 to include statements from Catherine Gundlach, PharmD, and Elizabeth Olberding, MD.

St. Luke's appreciated the opportunity to provide this additional information to BFS. We take these matters very seriously and immediately investigated and implemented interventions relative to the findings BFS identified during the exit conference. We had hoped that after reviewing the information provided, BFS would have reversed its initial findings of deficiencies relating to the following standards: A154, A166, A169, A178, A186, A187 and A188. The "Response to Preliminary Findings from the Bureau of Facility Standards Complaint Investigation, June 7-10, 2010" includes a summary of St. Luke's response, timeline, action steps and accountability for each of the Standards identified by the BFS surveyors at the conclusion of the survey. An addendum to this response was created as a result of the additional communications sent to BFS on June 15, 2010. During the two weeks since this document was provided to BFS, St. Luke's has continued to implement the action steps we

identified. For your convenience, I am enclosing a copy of the materials previously provided to BFS and evidence of additional action steps implemented.

I look forward to having an opportunity to discuss these matters with you later this week. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

Christine Neuhoff
System General Counsel
General Counsel, Boise/Meridian

Enclosures

cc: Sylvia Creswell, Idaho Bureau of Facility Standards
Gary Fletcher, CEO, St. Luke's Boise/Meridian
Barton Hill, MD, VP Medical Affairs, St. Luke's Boise/Meridian
Joanne Clavelle, VP Patient Care Services CNO, St. Luke's Boise/Meridian

St Luke's
Boise Regional
Medical Center
A St. Luke's Health System Hospital

190 East Bannock Street
Boise, Idaho 83712

stlukesonline.org

Gary L. Fletcher, CEO

July 13, 2010

Sent via facsimile to (208) 364-1888

Debby Ransom, RN, RHIT
Idaho Department of Health and Welfare
Bureau of Facility Standards
3232 Elder Street
PO Box 83720
Boise, ID 83720

Re: CMS Certification Number: 13-0006

Dear Ms. Ransom:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated June 30, 2010, advising us of your findings relative to state licensure requirements.

Enclosed you will find our Plan of Correction, on State Form 7EK211, describing procedures we have implemented and/or begun to implement in response to the processes cited as deficiencies. This document references the Plan of Correction, on Form CMS-2567, submitted to the CMS Regional Office on July 9, 2010, which demonstrates how we are incorporating our actions into our quality assessment and performance improvement program to prevent the likelihood that any similar event(s) will recur. A copy of Form CMS-2567 has been enclosed for your reference. Mrs. Joanne Clavelle, Vice President for Patient Care Services and Chief Nursing Officer, will be responsible for implementing our Plan of Correction.

The deficiencies cited were of great concern to St. Luke's. Immediately following our exit conference with your surveyor team, we began to develop and implement the enclosed Plan of Correction. As you will see on the enclosed Plan of Correction we are promptly and diligently addressing the cited deficiencies.

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

Christine Neuhoff
System General Counsel
General Counsel, Boise/Meridian

Enclosures

cc: Kate Mitchell, CMS – Survey and Certification
Gary Fletcher, CEO, St. Luke's Boise/Meridian
Barton Hill, MD, VP Medical Affairs & CMO
Pam Bernard, COO, St. Luke's Meridian
Chris Roth, COO, St. Luke's Boise
Joanne Clavelle, VP Patient Care Services & CNO, St. Luke's Boise/Meridian

St Luke's

CONFIDENTIALITY NOTICE

St. Luke's Regional Medical Center – 190 E. Bannock Street
Boise, ID 83702
Phone: (208) 381-1165 **Fax: (208) 381-1185**

E-mail: wilmesc@slrmc.org

Date: July 13, 2010

To: Debby Ransom, RN, RHIT
Idaho Department of Health & Welfare
Bureau of Facility Standards

From: Christine Neuhoff
General Counsel

Fax: 208.364-1888

Number of pages including cover: 62

PRINTED: 06/29/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS The following deficiencies were cited during the complaint survey of your hospital. The surveyors conducting the survey were: Patrick Hendrickson, RN, HFS, Team Lead Gary Banister, RN, HFS Gary Gulles, RN, HFS Teresa Hamblin, RN, MS, HFS Acronyms and terms used in this report include the following: ALF = Assisted Living Facility AMA = Against Medical Advice ED = Emergency Department HIM = Health Information Manager IV = Intravenous IM = Intramuscular LIP = Licensed Independent Practitioner MAR = Medication Administration Record MG = Milligrams PICU = Pediatric Intensive Care Unit PIE = Performance Improvement Event PRN = as needed Pt = patient RN = Registered Nurse SW = Social Worker	A 000		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on staff interview, review of patients' medical records, hospital policies and procedures, grievance documents, medical records requests, and restraint logs, it was determined the hospital failed to ensure patients'	A 115		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 7/9/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 115	Continued From page 1 rights were protected. This resulted in the inability of the hospital to ensure patients rights were respected and not violated. The findings include: 1. Refer to A123 as it relates to the failure of the hospital to ensure it provided a written notice of findings to patients who filed grievances. 2. Refer to A129 as it relates to the failure of the hospital to define how patients on suicide watch could access a telephone. 3. Refer to A131 as it relates to the failure of the hospital to ensure the rights of patients who were placed on involuntary holds, were protected. 4. Refer to A148 as it relates to the failure of the hospital to promote patient rights by releasing clinical record information. 5. Refer to A154 as it relates to the failure of the hospital to ensure patients, who were admitted to the hospital for medical clearance, pending a psychiatric admission, were free from the threat of restraints imposed as a means of coercion. 6. Refer to A166 as it relates to the failure of the hospital to ensure hospital staff incorporated restraint usage into patients plans of care. 7. Refer to A169 as it relates to the failure of the hospital to ensure restraint orders were not written as PRN orders. 8. Refer to A178 as it relates to the failure of the hospital to ensure patients who were restrained for the management of violent behavior, received a face-to-face evaluation by an appropriately	A 115		

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A 115	Continued From page 2 qualified person within 1-hour after the initiation of the intervention. 9. Refer to A186 as it relates to the failure of the hospital to ensure less restrictive interventions were attempted before the use of chemical and/or physical restraints. 10. Refer to A187 as it relates to the failure of the hospital to ensure that patients for whom chemical and/or physical restraints were used, had documentation in the medical records of the conditions and/or symptoms that warranted the use of the restraints. 11. Refer to A188 as it relates to the failure of the hospital to ensure that patients for whom chemical restraints were used, had documentation in their medical records of the response to the intervention. The cumulative effect of these negative facility practices seriously impeded to ability of the facility to promote and protect the rights of patients.	A 115	**In response to A-123** Action Plan Responsible Party: Vickie Whitham, MS, RN, NE-BC, director Nursing Administration Process improvements: ✓ 100% of patient grievances have been resolved for the time period reviewed by the surveyors (1/1/01-5/9/10). Finalized July 1, 2010. ✓ Plan to identify and implement an automated complaint reporting and tracking system. Project planning timeline being developed with anticipated implementation within 12 months. ✓ An additional Clinical Patient Relations Specialist position has been approved and is currently being recruited. Posted June 11, 2010	
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion. This STANDARD is not met as evidenced by: Based on staff interview and review of hospital policies and grievance files, it was determined the	A 123		

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A 123	Continued From page 3 hospital failed to provide written notice to 4 of 5 patients (#27, #30, #31, and #33) whose grievances were initiated between February and April, 2010 and whose grievance files were reviewed. This resulted in delayed responses to patients' greivances. The findings include: 1. A hospital policy, Patient Concern, Complaint, and Grievance Process, dated 6/04/09, had a section titled Investigating and Responding. It stated an acknowledgement letter would be mailed to the patient/representative within 7 days of receipt of a formal complaint/grievance. The timeframe for review and investigation depended on the severity of the complaint/grievance. After the review was complete, the hospital would provide the patient with a written notice of its decision. Whenever possible, concerns and grievances would be resolved within 30 days of receipt. More complex grievances might require more than 30 days to reach resolution. The policy did not address the procedure to be taken if and when the hospital was not able to investigate or resolve the complaints within the timeframes specified within the policy, such as whether they would contact the complainants to let them know of a delay. The above policy was not followed. Examples include: a. Patient #33 was a 31-year-old female admitted 3/23/10 and discharged 3/28/10. A Performance Improvement Event (PIE), dated 3/25/10, completed by an RN, described an event that resulted in patient injury. The report stated that after Patient #33 returned to her hospital room from the Endoscopy Department (where she had a bronchoscopy performed), she pointed out a	A 123	**In response to A-123 cont...** ✓ Update of Patient Complaint and Grievance policy to include the provision for patients will be informed in writing if the investigation into their grievance will take more than the "suggested" 30 day timeframe per our policy. Some grievances require extensive investigation and/or are subject to the Peer Review processes, requiring > 30 days for resolution. Approved June 22, 2010 ✓ The current process of reviewing a regular report to track unresolved grievances at past 30 days will continue. The Patient and Family Relations team will collaborate with department leadership team to fast track resolution where possible.	

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A 123	Continued From page 4 dark bruise to her left shoulder and stated a nurse in the Endoscopy Department told her to breathe deeply and then pinched her really hard causing the bruising. She was angry and upset. A bronchoscopy is a visual inspection of the tracheobronchial tree through the trachea. An email communication, dated 4/07/10, documented Patient Relations received the grievance. A Performance Improvement Concern Report, dated 4/07/10, documented Patient Relations then sent a letter to Patient #33 to acknowledge the grievance. This represented a period of 13 days after an RN initiated a written grievance on behalf of Patient #33. Patient #33 did not receive an acknowledgement letter within 7 days of initiating the grievance as required by hospital policy. The Performance Improvement Concern Report also indicated the grievance had been "sent for review" to a staff member who was assigned to be the lead reviewer. As of 6/08/10, the grievance file did not contain evidence the hospital had investigated or resolved the grievance, or sent a follow-up letter to Patient #33. This represented a period of 73 days, from the time the complaint had been initiated. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations explained because of a "paper system" there was a delay between the time the complaint was received in one department and the time it arrived with Patient Relations where complaint investigations were initiated. She also stated the complaint had been forwarded to the Endoscopy Department for investigation and review and they had not heard back from the department.	A 123	**In response to A-123 cont...** Action Plan Implementation: ✓ Management Council education regarding Patient Rights and Grievances. Held on June 17, 2010 ✓ Medical Executive Committee update regarding Patient Rights and Grievances. Held on June 22, 2010 QAPI Integration: ✓ PI Council received report regarding Patient Grievances. Held on June 16, 2010 ✓ Nursing Leadership Council received report regarding Patient Grievances. Held on June 28, 2010 ✓ Quality Committee of the Board received annual report regarding Patient Grievances. Held on July 6, 2010	

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A 123	Continued From page 5 Patient #33 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation as stated in hospital policy. b. Patient #31 was a 27-year-old female who came to the ED on 2/15/10. A hospital email communication, dated 2/16/10, indicated the patient's husband complained the ED had given his wife some pills that led to hemorrhaging and subsequent surgery. A Performance Improvement Concern Report, dated 2/23/10, indicated Patient Relations received the complaint and sent an acknowledgment to the complainant on 3/04/10 (23 days after the initial complaint was filed). Patient #31 did not receive an acknowledgement letter within 7 days of initiating the greivance as required by hospital policy. Patient Relations Notes, on the same form, indicated the complaint was "sent for review" on 4/12/10 to a staff member who was assigned to be a lead reviewer. This was 62 days after the complaint was initiated. The form further indicated Patient Relations requested an update on 5/25/10 from the lead reviewer to determine the status of the investigation. No additional information was present in the grievance file to indicate the complaint had been investigated or a letter of response had been sent as of 6/08/10, a total of 116 days after the initial complaint was received. During an interview on 6/07/10 at 3:20 PM, the Director of Nursing Administration reviewed the grievance file information and confirmed the delay in sending an acknowledgement letter and	A 123	**In response to A-123 cont...** ✓ Implementation of an audit tool and reporting process (through August 31, 2010) for the following metrics: 1) Percent of unresolved grievances > 30 days and 2) Percent of patients informed in writing if the investigation into their grievance would take > 30 days.	

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ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

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A 123	Continued From page 6 confirmed a written response had not yet been completed and sent. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations stated the complaint was first received in Patient Financial Services before being forwarded to Patient Relations. She did not realize until that morning (6/08/10) the hospital had reached a financial resolution with the complainants. She acknowledged a letter had not yet been written and sent to Patient #31. Patient #31 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation, as stated in hospital policy. c. Patient #27 was a 73-year-old male who was seen in the ED on 4/15/10. An email communication received in Patient Relations, dated 4/28/10, indicated Patient #27 had reported falling while getting into a cab after leaving the ED on 4/15/10. Patient #27 reported having had trouble walking and he was upset with ED staff for not taking him out in a wheelchair. His leg was scratched in the fall and subsequently became infected. A Performance Improvement Concern Report, dated 4/28/10, documented Patient Relations received Patient #27's grievance, mailed an acknowledgement letter to Patient #27, and initiated a request for a physician and additional staff to review the grievance. An additional Patient Relations note, dated 5/25/10, stated a request had been made for an update on the investigation. An email response to Patient Relations from the lead reviewer, dated 5/25/10, stated "sorry, I haven't." A second	A 123		

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A 123	Continued From page 7 follow-up email, dated 6/08/10, indicated Patient Relations made another attempt to contact the lead reviewer to see if the investigation was complete. As of 6/08/10, the grievance file did not contain evidence the hospital had completed an investigation and sent a written reply to Patient #27. This represented a period of no less than 38 days from the date the complaint was initiated. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations confirmed the investigation had not been completed and a letter of resolution had, therefore, not been sent. She explained, Patient Relations had not heard back from the ED Director who was investigating the complaint. Patient #27 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation, as stated in hospital policy. d. Patient #30 was a 68-year-old male admitted 4/19/10 and discharged 4/26/10. A Performance Improvement Event, dated 4/28/10, completed by an RN, documented the family had reported multiple concerns regarding medical and nursing care issues. A Performance Improvement Concern Report, dated 4/28/10, indicated Patient Relations sent the complainant a card to acknowledge the complaint and then forwarded the complaint for review to a staff member who was assigned to be a lead reviewer. An email from hospital staff, dated 5/10/10, documented the investigation was complete. The	A 123		

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A 123	Continued From page 8 grievance file was reviewed. There was no evidence, as of 6/08/10, the complainant had been sent a written response regarding the resolution of the grievance. This was 41 days after the initial complaint was received. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations confirmed the investigation was complete and the letter was due to be sent but had not yet been sent. Patient #30 did not receive written notice of the hospital's decision regarding her grievance with 30 days of initiation, as stated in hospital policy. 2. A hospital document written by the Manager of Patient Relations, titled Patient and Family Relations Quarterly Departmental Review (1st quarter [September 30, 2009 through December 31] and 2nd quarter FY 2010 [January 1 through March 31]), dated 4/20/10, described challenges facing the Department of Patient Relations, including: 1) an increase in complaints, 2) staff turnover of Patient & Family Relations staff, 3) loss of one position, 4) more complex complaints received requiring more time, and 5) the need for additional support. During an interview on 6/07/10 at 3:30 PM, the Director of Nursing Administration explained that responses to grievances may have been delayed in the above referenced examples because of staffing issues. She said they had one open position and an employee had been out sick. Also, there had been job transitions among staff. During an interview on 6/08/10 at 8:00 AM, the Manager of Patient Relations stated it was their goal to resolve 90% of complaints and provide a	A 123		

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A 123	Continued From page 9 written response within 30 days. In previous quarters they had met or exceeded this goal. She acknowledged that during the current quarter, beginning April 1, they had gotten behind, probably because they had been down one staff since 4/07/10 and another staff had been ill. She also stated it had been difficult at times to get responses from departments who were assigned to investigate complaints. She stated the departments were very busy and had a hard time getting to investigations. It was her desire to change the model and have staff from the Patient Relations Department lead the investigations. She stated complaints had increased, the hospital was growing, and they lacked staff for follow-through with complaints. The hospital failed to investigate, resolve, and respond to complainants in writing within the 30 day timeframe as stated in hospital policy.	A 123		
A 129	482.13(b) PATIENT RIGHTS: EXERCISE OF RIGHTS Patient Rights: Exercise of Rights This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure access to a telephone for 2 of 9 patients (#16 and #17) whose psychiatric records were reviewed. This limited the ability of patients to communicate and resulted in a violation of patient rights. The findings include: 1. Patient #16 was a 20-year-old female, admitted to the hospital on 4/23/10, after a self-reported medication overdose. Patient #16's record documented she was on suicide watch	A 129		

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A 129	Continued From page 10 and was assigned a 1:1 sitter. Patient #16's record contained a nursing note, dated 4/26/10 at 12:16 PM, which stated Patient #16 had a cell phone which the staff attempted to remove from her possession. The note documented that Patient #16 refused to give the cell phone to the staff and was instructed that if she did not cooperate and give up the cell phone, she would be placed in restraints. The hospital's policy titled Care of Patients with Threatened or Actual Suicide Attempt, dated 4/12/09, stated staff would remove any items from the room that could potentially be used for self-harm. The policy referred to the hospital's Safety Checklist. The hospital's Safety Checklist, that was not dated, instructed staff to remove telephone cords from the room and store them in a locked cupboard. Neither the policy, nor the checklist, provided direction to staff as to how to accommodate the patient's desire or need for a telephone. 2. Patient #17 was a 63-year-old female, admitted to the hospital on 1/07/10, after a self-reported overdose. Patient #17's record documented she was on a suicide watch and had a 1:1 sitter. A nursing shift note, dated 1/11/10 from 3:00 PM to 8:00 PM, stated Patient #17 was talking on the phone. The Clinical Supervisor of the Medical floor, was interviewed on 6/08/10 starting at 12:05 PM. He stated Patient #17 did have a cell phone during most of her hospital stay. He stated that this was an oversight and when it was identified that Patient #17 had a cell phone, the phone was removed from her possession. He stated that patients who were on suicide watch were not	A 129	**In response to A-129** Action Plan Responsible Party: Tom Aronson, MBA, LCSW, director of Clinical Social Services Process Improvements: ✓ Update of the Suicide Precautions policy with the following statement: "If the telephone is removed from the room or locked in a secure cupboard for safety reasons, a phone is to be made available upon patient request. The patient will be supervised while using the phone." Finalized June 11, 2010. ✓ Update of the Suicide Precautions Checklist to include the following instructions, "The patient is to be informed they should contact the RN if they wish to contact someone outside the hospital and reasonable efforts will be made to accommodate the patient's wishes. The patient will be supervised for safety while using communication devices." Finalized June 28, 2010.	

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A 129	Continued From page 11 allowed a telephone. The hospital's Social Service Supervisor was interviewed on 6/08/10 starting at 10:35 AM. He stated that patients on suicide watch did not have a telephone in their room. He was unsure as to how staff was to allow patients to use the phone. Patient #17's physician was interviewed on 6/08/10 starting at 1:00 PM. She stated that Patient #17 did have a cell phone during most of her hospital stay. She also indicated this was an oversight and when it was identified that Patient #17 had a cell phone, the phone was removed from her possession. She was unsure as to how staff were to allow patients to use the phone or if they were even allowed to use one. Patient #17's telephone use was restricted due to her status of being on suicide watch. 3. Staff were interviewed regarding their understanding of patients'use of telephones while on suicide watch. Staff N, an RN, was interviewed on 6/08/10 starting at 2:23 PM. She stated that patients on suicide watch did not have a telephone in their room and were not allowed to use a telephone. Staff P, a RN, was interviewed on 6/08/10 starting at 2:43 PM. She stated that patients on suicide watch did not have a telephone in their room and she did not know how patients were to use the phone. A RN was interviewed on 6/08/10 starting at 2:25 PM. She stated it was up to the nurse as to whether patients on suicide watch could use a	A 129	**In response to A-129 cont...** ✓ The medical record for patients on suicide precautions will be reviewed during rounds by the Nursing Administrative Supervisor, Charge Nurse, or Social Work. Initiated by August 31, 2010. Action Plan Implementation: ✓ Policy changes communicated to the Interdisciplinary Clinical Education Team and Clinical Education Service Team. Communicated on June 16, 2010 ✓ Policy changes communicated to the Nursing Education Council. Communicated on July 6, 2010. QAPI Integration: ✓ Implementation of an audit tool and reporting process (through August 31, 2010) for the following metric: 1) Percent of nurses caring for patients on suicide precautions who report informing them of their right to access the telephone.	

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A 129	Continued From page 12 telephone. A CNA was interviewed on 6/08/10 starting at 2:07 PM. She stated it was up to the nurse as to whether patients on suicide watch could use a telephone. Hospital staff were not sufficiently trained on how to promote and protect the rights of each patient. The hospital failed to promote patient rights in its policies and practices related to telephone use.	A 129		
A 131	482.13(b)(2) PATIENT RIGHTS: INFORMED CONSENT The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure the rights of 2 of 2 patients (#2 and #14) reviewed, who were placed on involuntary holds, were encouraged and protected by allowing them to participate in decisions regarding their care. This resulted in 2 patients being placed on involuntary holds for the convenience of staff for discharge planning purposes. The findings include:	A 131		

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A 131	Continued From page 13 Idaho statute 66-326 states a "person may be detained at a hospital at which the person presented or was brought to receive medical or mental health care, if the peace officer or a physician medical staff member of such hospital has reason to believe that the person is gravely disabled due to mental illness or the person's continued liberty poses an imminent danger to that person or others, as evidenced by a threat of substantial physical harm..." Two patients (#2 and #14) were placed on involuntary holds without an evaluation by a physician that their continued liberty posed an imminent danger to themselves or others. Examples include: 1. Patient #2's medical record documented an 81-year-old female who was admitted to the hospital on 3/04/10 and was discharged on 3/05/10. She presented to the emergency department on 3/04/10 at 9:45 PM. A History and Physicial dictated at 12:43 AM on 3/05/10, stated Patient #2 had fallen and suffered a contusion of her forehead and laceration of her nose which required suturing. The report stated Patient #2 thought she had slipped and fallen. The report stated this was her third admission to the emergency department in 2 days. The report stated she had been seen first for a urinary tract infection and confusion. The report stated she had returned later and been treated for confusion related to dehydration. She was rehydrated and sent home again before returning a third time. The report stated "I get the impression that she is markedly depressed as well as somewhat paranoid and concerned about being here in the hospital." The report stated Patient #2 had a history of "...depression with possibly some psychotic features..." The report stated her affect was flat but she was oriented to person, place,	A 131	**In response to A-131** Action Plan Responsible Party: Tom Aronson, MBA, LCSW, director of Clinical Social Services Process Improvements: ✓ Immediate process change where Social Work leadership would be notified of all patients being placed by a physician on an involuntary mental health hold. Implemented June 11, 2010 ✓ Education of Emergency Medicine of Idaho physicians and St. Luke's Internal Medicine Hospitalists regarding criteria for involuntary mental health hold placement. Communications sent by July 7, 2010. ✓ The medical record for patients on mental health holds will be reviewed during rounds by the Nursing Administrative Supervisor, Charge Nurse, or Social Work. Initiated by August 31, 2010.	

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A 131	Continued From page 14 and time. The report also stated Patient #2 did not appear to be in any distress but was tearful. The report stated the plan was to admit Patient #2 for hydration and "...possible consideration of a psychiatric evaluation and maybe transferred to [a geriatric psychiatric hospital] for medication evaluation and adjustment." The next physician note was dated 3/05/10 at 3:00 PM. The entire note stated "Pt alert in no distress. Refused transfer to [the geriatric psychiatric hospital]. When trying to discuss says 'I'm doing horrible. I will make other arrangements rather than go to [the geriatric psychiatric hospital].' Orders including hold for psychiatric debility were signed. Transfer to [the geriatric psychiatric hospital] ." No evaluation of Patient #2's psychiatric condition was documented in the medical record. No description of Patient #2's behavior that indicated she was a danger to herself or others was documented. The RN documented on the Cumulative Flowsheet Report section of the electronic medical record, at 10:44 AM on 3/05/10. Under the heading Psycho-Social Assessment, the software prompted "Agitated," to which the nurse answered "Yes." No other indication of Patient #2's agitation or description of her behavior was documented. This was the last note in the medical record by a nurse who provided care to Patient #2. A note documenting the time of discharge and condition of the patient at discharge was not present in the medical record. A tracking document from the ambulance dispatch, labeled Transfer information, stated Patient #2 was transported by ambulance at 4:34 PM on 3/05/10 to a geriatric psychiatric hospital.	A 131	**In response to A-131 cont...** ✓ Implementation of a checklist to be used when placing a patient on an involuntary mental health hold. Implement by August 31, 2010. Action Plan Implementation: ✓ Face-to-face education for social workers was held to review involuntary mental hold policies, including documentation requirements. Held on June 14, 2010 ✓ Management Council education regarding involuntary mental health holds. Held on June 17, 2010 ✓ Medical Executive Committee update regarding involuntary mental health holds. Held on June 22, 2010 ✓ Nursing Administrative Supervisor update regarding involuntary mental health holds. Held on July 7, 2010.	

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A 131	Continued From page 15 A Case Management Encounter Note, dated 3/05/10 at 11:55 AM, stated Staff C, the RN Case Manager, met with Patient #2 and her daughter. The note said they discussed the option and possibility of discharging her to the geriatric psychiatric hospital. The note stated Patient #2 currently lived in an ALF and wanted to return there. The note stated, "Pt, at this point, is unsure if she will go to [the geriatric psychiatric hospital] voluntarily. May need to initiate a hold." No behavior was documented indicating Patient #2 was a danger to herself or others or gravely disabled. A Social Service Assessment was documented at 12:18 PM on 3/05/10 by Staff B, a Social Worker. The assessment quoted directly stated: "SW Recurrent Illness Patient SW Multiple Health Issues Patient Depressed Mood Patient Hallucinations/Delusions Patient Mental Health Issues Patient Cope with Hospitalization Yes Comfortable asking questions Yes Income to meet basic needs Yes Understand Prognosis Yes Adequate Family Support Yes Adequate Social Support Yes" This was the assessment as it was provided to surveyors. The Social Service Assessment included a Social Service Focus Note by the same Social Worker at the same time. The Focus Note stated the Social Worker met with Patient #2 and her daughter. The Focus Note stated Patient #2 had been	A 131	**In response to A-131 cont...** QAPI Integration: ✓ Implementation of an audit tool and reporting process (through August 31, 2010) for the following metric: 1) Percent compliance with completion of involuntary mental health hold documentation requirements.	

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A 131	Continued From page 16 diagnosed with "Delusional Disorder a few years ago and had spent 3 weeks in a psychiatric hospital in [another state]." The Focus Note stated Patient #2's symptoms had been controlled with medication but, after a change of medication in February 2010, she "has not presented as she had previously, according to [the daughter]...[The daughter] and her brother have an appt [appointment] with an attorney next Tuesday to file for legal guardianship of their mother. He will arrive tomorrow. The pt presented as very flat and withdrawn. She did not want to talk to SW....SW called [the geriatric psychiatric hospital] regarding not knowing who, if anyone, may have medical POA for the pt. They can help work this out once the pt is there and the daughter can sign pt in. If the pt attempts to leave, however, then the POA would need to be notified. SW discussed with the case mgr about the pt meeting criteria for a hold for being gravely disabled if the attending MD wanted to pursue that route." The last note on the medical record was dated 3/05/10 at 4:33 PM. The note was by the social worker. It stated the patient had been accepted for care by the physician at the geriatric psychiatric hospital. It stated "Transport notified" and said paper work was being prepared for the receiving hospital. A note documenting the discharge of Patient #2, including the time of discharge, the mode of transport, and the condition of the patient at discharge, was not present in the record. A specific assessment of Patient #2's mental state or behavior was not documented during her stay. The specific behavior(s) that warranted placing Patient #2 on an involuntary hold were not documented.	A 131		

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A 131	Continued From page 17 The Application of Commitment of the Mentally Ill, dated 3/05/10 at 1:31 PM, signed by the physician and filed with the court, stated Patient #2 had been on a steady mental decline, according to her daughter. The application stated Patient #2 had a previous psychiatric diagnosis and had been having paranoid thoughts. The application stated Patient #2 was not able to complete her activities of self-care, had a flat affect, and did not want to talk much today. The application did not state a specific behavioral reason for the involuntary hold. Patient #2's Interdisciplinary Care Management Plan, dated 3/04/10 and 3/05/10, did not contain a plan related to her behavior or psychological issues. The Patient Focus List, part of the plan, stated "Pt will be able to verbalize needs for self-care." No plan for this was documented. Staff B, Patient #2's Social Worker, was interviewed on 6/08/10 at 10:30 AM. Staff B was asked what specific behavior Patient #2 exhibited to warrant placing her on an involuntary hold. Staff B could not state one. She stated she did not assess Patient #2's mental status or psychological status. When asked why the patient was placed on an involuntary hold, she replied Patient #2 could not take care of her activities of daily living and had a mental health diagnosis. Staff D, the physician who signed the involuntary hold, was interviewed on 6/09/10 at 3:05 PM. She stated Patient #2 was admitted by the on-call physician. She said she was told by the hospital that Patient #2 needed to leave, to be transferred, so she left her private practice and came to the	A 131		

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	130006	A. BUILDING _____ B. WING _____	C 06/10/2010

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A 131	Continued From page 18 hospital. Staff D stated Patient #2 was alert and probably oriented to person, place, and time. She said much of her assessment of Patient #2 was based on her previous history. She stated Patient #2 was psychotic but she did not have a specific example of the patient's psychotic behavior. She said Patient #2 was angry and could not be reasoned with. She said Patient #2 did not want to be in the hospital and did not want to be transferred to another hospital. She said she did not know if other possible placements for Patient #2 had been discussed. Staff A, the nurse who cared for Patient #2 on 3/05/10, was interviewed on 6/10/10 at 9:20 AM. She stated the last nursing care note was documented at 10:44 AM on 3/05/10. She stated she did not remember Patient #2 and did not know what she meant when she documented the patient was "Agitated." She stated this term was chosen from a menu of choices in the electronic medical record. She stated a discharge note was not documented. Patient #2 was placed on an involuntary hold without an evaluation of her mental status and for the convenience of hospital staff in order to facilitate discharge planning. 2. Patient #14's medical record documented a 69-year-old male who was admitted to the hospital on 2/12/10 and was discharged on 2/15/10. Diagnoses included dementia, homosexual delusion, and diabetes. An involuntary hold was documented on 2/15/10. The discharge summary, dated 3/23/10, stated Patient #14, "Did continue to have delusional thoughts regarding homosexuality...The	A 131		

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A 131	Continued From page 19 [discharge] plan had been that the patient move from his home setting to an assisted living facility. We were having difficulty finding that due to these delusions, and instead he was transferred to behavioral health." The discharge summary did not state that Patient #14 was placed on an involuntary hold or the reasoning behind that decision. The Emergency Department record, dated 2/12/10, stated Patient #14 had dementia and his symptoms had been worsening over the past several months. The record stated the patient had answered the door naked and had spoken on the telephone to a family member of homosexual delusions. A psychiatric examination, dated 2/12/10 at 10:52 PM, stated Patient #14 had a calm affect but described receiving "messages that come from his head" regarding homosexual activities. The note stated Patient #14 denied wanting to harm himself or others. A physician Progress Note, dated 2/13/10 at 12:45 PM, stated "Plan 1. Not safe for discharge to live alone. Must find appropriate ALF. Discussed [with] patient & son at bedside-both agreeable." A physician Progress Note, dated 2/14/10 at 11:45 AM, stated Patient #14 had no complaints. The note stated Patient #14 was sexually inappropriate with a male RN the evening before but there was no "focus note to support." Patient #14 was described as "Alert and oriented to hospital...Plan: ...Await ALF placement." A physician Progress Note, dated 2/15/10 at 9:45 AM, stated Patient #14 was sitting in the hallway with a sitter. The note stated he was aware he was in St. Lukes Regional Medical Center and the physician was covering for Patient #14's regular physician. The note stated "He	A 131		

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A 131	Continued From page 20 continues agreeable to ALF placement." A Progress Note by the Case Manager, dated 2/15/10 at 3:50 PM, stated she met with Patient #14's son and daughter and the Admissions Director for the ALF. The note stated the ALF Director had contacted a geriatric psychiatric hospital and thought Patient #14 would be appropriate for admission there before coming to the ALF. The note stated the Social Worker sent the referral to the geriatric psychiatric hospital and the family was available for transport. A corresponding order by the physician, dated 2/15/10 at 4:40 PM, stated if the geriatric psychiatric hospital accepted Patient #1, to discharge him to his family for transfer there. A physician Progress Note, dated 2/15/10 (no time documented), stated "Discussed [transfer with] patient & he is willing for transfer to [geriatric psychiatric hospital]." A telephone order, dated 2/15/10 at 5:50 PM, stated "place pt on mental health hold." No progress note by the physician accompanied the order. A Psychological and Social Assessment by the RN, dated 2/15/10 at 9:06 AM, stated "Disoriented-Yes." No clarification was documented and no specific behaviors were documented. A Psychological and Social Assessment by the RN, dated 2/15/10 at 3:35 PM, stated "Disoriented-Yes." Again, no clarification was documented and no specific behaviors were documented. No nursing note on 2/15/10 documented Patient #14 had any behavioral problems or was a danger to himself or others or described that he was gravely disabled. A progress note by the Case Manager, dated	A 131		

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A 131	Continued From page 21 2/15/10 at 4:43 PM, stated she met with Patient #14 and his son and daughter. The note stated the ALF representative wanted the patient to go to the geriatric psychiatric hospital prior to admission to the ALF. The note stated a referral was sent to the receiving hospital. A Social Service Focus Note by Staff F, the Social Worker, dated 2/15/10 at 4:45 PM, stated she called the geriatric psychiatric hospital and beds were available. The Social Service Focus Note by Staff F, dated 2/15/10 at 6:19 PM, stated because Patient #14's Durable Power of Attorney for Health Care was executed 2 days prior to his hospitalization, the geriatric psychiatric hospital wanted Patient #14 placed on a "Physician Mental Hold." The note stated Staff F informed Staff E, Patient #14's physician, and completed an application for commitment. The note did not include an assessment of Patient #14's psychological status or documentation of specific behaviors to indicate he was a danger of self or others or gravely disabled. The final note in Patient #14's medical record was a "CM Focus Note," dated 2/15/10 at 6:19 PM. It stated Patient #14 was placed on an involuntary hold and the family would transport him to the receiving hospital. An involuntary hold is a legal process where a patient is taken into custody by the hospital. The note did not explain why Patient #14 was being released to his family. A focus note stating the time and circumstances of Patient #14's discharge was not documented. Patient #14's Interdisciplinary Care Management Plan, dated 2/13/10-2/15/10, did not mention psychological status or direction to staff regarding inappropriate behaviors. A Discharge Planning column, dated 2/15/10, stated, "Pt placed on Physician hold @ request of Dr. [name], admitting MD at [geriatric psychiatric hospital]. Son,	A 131		

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A 131	Continued From page 22 daughter will transport." Staff E, Patient #14's physician, was interviewed on 6/07/10 at 4:25 PM. He stated he did not evaluate Patient #14 prior to placing him on an involuntary hold. He stated Patient #14 was placed on a hold because the social worker said the physician at the receiving hospital would not admit the patient unless he was placed on a hold. He stated he did not speak with the receiving physician. Staff F, the Social Worker for Patient #14, was interviewed on 6/08/10 at 2:05 PM. She reviewed the medical record and confirmed she did not evaluate Patient #14's psychological status. She stated Patient #14 was placed on an involuntary hold for discharge planning purposes. She stated the hospital sometimes allowed patients on involuntary holds to be transported by family members. Staff G, the RN assigned to Patient #14 on 2/15/10, was interviewed on 6/08/10 at 2:40 PM. She stated Patient #14 seemed "normal and coherent" although he was sexually inappropriate with young males. She stated Patient #14 had wandered into a 21 year old male's room and said something inappropriate. She stated he was easily redirected by staff. She stated female staff were assigned to him and he was compliant and cooperative with them. She stated he just needed supervision. She stated his plan of care did not include any behavioral interventions. She said staff just reoriented him if needed it and he "was fine" in the room. Patient #14 was placed on an involuntary hold without an evaluation of his mental status and for	A 131		

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A 131	Continued From page 23 the convenience of hospital staff in order to facilitate discharge planning.	A 131	**In response to A-148**	
A 148	482.13(d)(2) PATIENT RIGHTS: ACCESS TO MEDICAL RECORD The patient has the right to access information contained in his or her clinical records within a reasonable time frame. The hospital must not frustrate the legitimate efforts of individuals to gain access to their own medical records and must actively seek to meet these requests as quickly as its record keeping system permits. This STANDARD is not met as evidenced by: Based on review of hospital policies and documentation of requests for release of medical records and interviews with staff and patients, it was determined the hospital failed to promote patient rights by releasing clinical record information for 2 of 2 patients (#18 and #19) whose adoptive parent requested records. This frustrated the legitimate efforts of a parent to gain access to her adopted childrens' medical records. The findings include: The hospital documented receiving medical record requests on 3/27/09 and 2/18/10 from an adoptive parent for Patient #18 and Patient #19. A computer-generated medical record form showed an "A" next to Patient #18's name and Patient #19's names, indicating the record request was still active or the request had not been finalized. A letter, dated 2/01/10, from a parent of Patients' #18 and #19, was attached to one of the requests. In the letter, the parent stated she had made 5 prior requests for release of information in the previous 4 years, none of which had been fulfilled. She further stated in the letter she had received "an irate phone call" from	A 148	Action Plan Responsible Party: Pat Johnson, PhD, director of Education Process Improvements: ✓ Updated of the Confidentiality and Security of Patient Information policy to clarify the rights of adoptive parents in accessing the medical records of their adoptive children. This policy revision included the provision that anyone being denied access to their medical records will be informed in writing of their right to contact the Patient Relations department for follow-up. Finalized June 11, 2010.	

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A 148	Continued From page 24 someone in the medical records department informing her that she did not have to send 5 requests because it would not make them send the records any faster and she should stop sending requests for records. A phone interview was conducted on 6/07/10 at 2:10 PM with the parent who had requested medical records on her two adoptive children (Patient #18 and Patient #19). She stated she had made multiple requests to have medical records released and had completed the hospital's required paperwork and provided proof of her legal relationship to her children. She stated she had not received the records or any written response from the hospital to her requests. She stated she had two phone conversations with representatives from the Medical Records Department. During one phone conversation, she stated she was told to stop sending requests for medical records, and during a second phone call she was told the childrens' records were closed due to adoption and would not be released. She explained her children were disabled and under medical care and she and the physicians did not want to repeat unnecessary genetic tests that may have previously been conducted. She also stated that she had looked into Idaho statutes about release of records and understood she had a right to access her childrens' medical information. On 6/08/10 at 12:40 PM, an interview was conducted with the Boise HIM Manager and the Director of Nursing Administration. The Boise HIM Manager acknowledged two unfulfilled requests (dated 3/27/09 and 2/18/10) for medical records from an adoptive parent for two daughters. She stated she realized in looking at	A 148	**In response to A-148 cont...** Action Plan Implementation: ✓ The adoptive mother of the two minor adoptive children in question was contacted by telephone and all requested medical records were sent to her attention by Federal Express, in accordance with the revised policy. Patient's mother contacted by phone on June 11, 2010. Records were sent on June 14, 2010 and the mother was contacted on June 15, 2010 to confirm receipt of the records. ✓ Health Information Management staff were educated on the policy clarification. Held on June 11, 2010. QAPI Integration: ✓ Percent of Health Information Management staff that have completed the required education on the revised policy by August 31, 2010.	

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A 148	Continued From page 25 the documentation that the hospital had not followed-up with the parent and should have at the time. She also stated the first request had been shredded but should not have been shredded. Although the hospital would not have released the medical record information to the requestor based on the hospital's policy (referenced below), their department should have sent a response to the parent. The hospital's policy, Confidentiality and Security of Patient Information in Health Information Management (HIM), dated 1/25/10, stated that in order to protect all parties' identities, records on adopted infants would be released only by court order once the child had been discharged from the hospital and identifying information (of birth parents) would be deleted unless the court specified otherwise. The Boise HIM Manager was interviewed on 6/07/10 at 2:35 PM. Her remarks were consistent with the above-referenced policy. She explained the hospital released information on adoptive children to the adoptive agency or an adoptive parent only by court order. When released, the information regarding the birth parents was "blacked out" to protect the privacy of the birth parents. When asked how the policy or practice was established, she explained it was based on information from the Idaho Hospital Association. The Health Information Manager provided the reference from the Idaho Hospital Association upon surveyor request. The Guidebook Issues in Health Care Management, published in 2008 by the Idaho Hospital Association had a section titled Release of Information Regarding Adoptions. It	A 148		

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A 148	Continued From page 26 recommended that each institution's policy stipulate that the adopting parents had the right to inspect the adoptee's medical records, consistent with state statues on minority. However, such inspection should not include the sealed birth certificate, or identifying information on the child's birth parents. Thus, it was necessary for the institution to take measures to mask the identity of the birth parents. During an interview on 6/08/10 at 12:40 PM, surveyors asked the Boise HIM Manager how the hospital's policy regarding not releasing medical records to adoptive parents was derived from the reference provided (Guidebook Issues in Health Care Management). The Boise HIM Manager stated she realized there was "a gap" and it would be necessary to revisit the policy and perhaps seek legal council on the appropriateness of withholding medical records from adoptive parents. The hospital failed to protect and promote adoptive parents' rights to access medical information on their adoptive children.	A 148	**In response to A-154** Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services Process Improvements: ✓ Draft of revised restraint policy, order sets, checklist, and audit process. Draft completed on June 29, 2010. ✓ Approval of revised Restraint policy and order sets, checklist and audit process. by August 31, 2010. ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010. Action Plan Implementation: ✓ Management Council update regarding Restraint ordering and use. Held on June 17, 2010.	
A 154	482.13(e) USE OF RESTRAINT OR SECLUSION Patient Rights: Restraint or Seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time. This STANDARD is not met as evidenced by:	A 154		

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A 154	Continued From page 27 Based on staff interview and review of medical records, it was determined the hospital failed to ensure 2 of 2 patients (#16 and #38) reviewed, for whom chemical and/or physical restraints were used, were free from the threat of restraints imposed as a means of coercion. This resulted in patients' rights being violated. The findings include: 1. Patient #16 was a 20-year-old female, admitted to the hospital on 4/23/10, after a self-reported overdose. Patient #16's record documented that she was on a suicide watch and had a 1:1 sitter. Patient #16's record contained a nursing note, dated 4/26/10 at 12:16 PM, which stated Patient #16 had a cell phone which the staff attempted to remove from her possession. The note documented that Patient #16 refused to give the cell phone to the staff so staff instructed the patient that if she did not cooperate and give up the cell phone, she would be placed in restraints. The documentation was confirmed during an interview by the hospital's Director of Accreditation and Nursing Operations on 6/09/10 at 2:00 PM. Patient #16 was threatened with the use of restraints. 2. Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10 after a self-reported polydrug ingestion. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 wanted her IV out and her oxygen saturation monitor off. The note further documented that Patient #38 stated, "It's my time to die. God told me it's my time. I had	A 154	**In response to A-154 cont...** ✓ Medical Executive Committee education regarding restraint use. Held on June 22, 2010. ✓ Nursing Practice Council and Nursing Education Council education regarding restraint use. Held on July 6, 2010. ✓ Administrative Supervisor update regarding restraint use. Held on July 7, 2010. ✓ Management Council communication regarding the expectation that restraints are never to be used as a form of coercion or punishment. Sent July 8, 2010. QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metric: 1) Percent of direct-care RN staff (excluding staff that are on leave) that have reviewed the revised policy as indicated by a signed acknowledgement. This reporting process will end as of August 31, 2010.	

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A 154	Continued From page 28 one thing to do, and I've done it." The note explained the physician came into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. The documentation was confirmed during an interview by the hospital's Director of Accreditation and Nursing Operations on 6/09/10 at 1:40 PM. The hospital failed to ensure Patient #38 was free from the threat of restraints as a means of coercion.	A 154	**In response to A-166** Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services Process Improvements: ✓ Draft of revised restraint policy, order sets, checklist, and audit process. Draft completed on June 29, 2010. ✓ Approval of revised Restraint policy and order sets, checklist and audit process. by August 31, 2010. ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010. Action Plan Implementation: ✓ Management Council update regarding Restraint ordering and use. Held on June 17, 2010.	
A 166	482.13(e)(4)(i) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure hospital staff incorporated restraint usage into the plans of care for 2 of 2 patients (#16 and #38) reviewed, who were chemically and/or physically restrained. This had the potential to interfere with coordination of patient care and could not direct staff in lesser interventions before restraining patients. The findings include: The Hospital's policy titled Restraint, last revised on 12/14/09, stated, "The use of restraints will be in accordance with written modification to the patient's plan of care..." This policy was not followed. Examples include:	A 166		

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A 166	Continued From page 29 1. Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10 after a self-reported polydrug ingestion. The ED History and Physical dictated by the physician on 4/30/10 at 10:58 PM, stated that Patient #38 reported she had taken a half bottle of Extra Strength Tylenol, 2 full boxes of caffeine pills, and 2 full boxes of Benadryl. The History and Physical stated that Patient #38 remained quite alert without obvious symptoms in the ED. The ED History and Physical stated Patient #38's blood Tylenol levels were less than 10. This was a normal result. The ED History and Physical documented the plan of treatment was to repeat Patient #38's Tylenol levels, and "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the calender year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, that stated Patient #38 wanted her IV line out and her oxygen saturation monitor off. The note further documented that Patient #38 stated, "It's my time to die. God told me it's my time. I had one thing to do, and I've done it." The note explained that the	A 166	**In response to A-166 cont...** ✓ Medical Executive Committee update regarding restraint use. Held on June 22, 2010. ✓ Nursing Practice Council and Nursing Education Council education regarding restraint use. Held on July 6, 2010. ✓ Administrative Supervisor update regarding restraint use. Held on July 7, 2010. ✓ Focus on care plan documentation for patients placed on mental health holds, restraints for violent behavior, suicide precautions, and other behavioral health interventions by August 31, 2010. QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metrics: 1) Percent of direct-care RN staff (excluding staff that are on leave) that have reviewed the revised policy as indicated by a signed acknowledgement.	

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A 166	Continued From page 30 physician had come into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders RESTRAINTS form, dated 5/01/10 at 1:00 AM. The progress notes side of the Restraint form titled CLINICAL JUSTIFICATION FOR RESTRAINTS stated Patient #38 was pulling at her IV line again and was expressing suicidal desire and will "sedate/restrain PRN." The sections of "Demonstrates attempts to remove airway or other life saving devices" and "Violent/self-destructive behavior" were checked. On the Doctor's Orders side of the Restraint form, under the "Nonviolent Behavior" section, the box beside "Initiate/Renew Restraint Use" was checked. On the Restraint form, a sentence directly above the physician's dated signature, stated "I have examined the patient and certify the above restraint order is indicated." The Restraint form was signed by the physician on 5/01/10 at 1:00 AM. On the same date, 5 minutes after signing the Doctor's Orders side of Restraint form, at 1:05 AM, the physician ordered Versed (a medication used to induce sleepiness and amnesia during surgery) 4-6 mg IV every 1 hour as needed for excessive agitation. This order was written and signed by the physician in the Doctor's Orders column of a Doctor's Orders and Progress Notes form. The 2010 Nursing Drug Handbook states Versed is a preoperative sedative and a medication for conscious sedation. The medication was listed as to induce sleepiness and amnesia. Versed	A 166	**In response to A-166 cont...** ✓ 2) Percent compliance with required restraint documentation. This reporting process will end as of August 31, 2010.	

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A 166	Continued From page 31 was listed as to be given before and/or during surgeries to induce general anesthesia. The listed dosing recommendations for children ages 12 to 16 was to initially give no more than 2.5 mg IV. The 2010 Nursing Drug Handbook states that Versed dosing may be increased to a total dose of up to 10 mg to reach the desired level of sedation. Patient #38's MAR documented she had received 4 mg of Versed on 5/01/10 at 1:22 AM, 3:00 AM, and 6:28 AM, for a total of 12 mg over a period of 5 hours and 6 minutes. The medical record did not document the reason the medication was given at 3:00 AM and 6:28 AM. Patient #38's POC was not modified to reflect the chemical restraint orders or the behaviors and interventions to the behaviors to include medication administration. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM. She had reviewed Patient #38's record. She stated Patient #38's POC was not updated because the hospital staff did not chemically restrain the patient and, therefore, the POC did not have to be updated. Hospital staff failed to incorporate restraint usage into Patient #38's plan of care. 2. Patient #16 was a 20-year-old female admitted to the hospital on 4/23/10, after a self-reported drug ingestion. Patient #16's record documented she was on a suicide watch and had a 1:1 sitter. A physicians written order dated 4/23/10 at 10:10 PM, ordered the nursing staff to administer hard	A 166		

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A 166	Continued From page 32 restraints on all four extremities. Hard restraints refer to leather material with belts to secure the patient's extremities to the bed. The physician documented on the Emergency Department section of the medical record, at 10:39 PM on 4/23/10. Under the heading History of Present Illness, was entered, "...very belligerent and fighting treatment and she was placed in soft restraints after which she became somnolent." Soft restraints were devices made of soft material that are designed to safely fit around the wrists, ankles, or chest of a patient to prevent patients from harming themselves. Patient #16's record contained a nursing note, dated 4/25/10 at 6:22 PM, which stated Patient #16 was agitated and yelling. The note indicated she removed her telemetry unit and threw it. Documented within the hospital's Interdisciplinary Care Management Plan, dated 4/25 and 4/26 was, "Soft restraints prn, 1 wrist and 1 ankle..." There was no documentation in Patient #16's Interdisciplinary Care Management Plan, to include alternative or less restrictive measures to be attempted before applying soft or hard restraints prn. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM and she reviewed Patient #16's record. She confirmed Patient #16's Interdisciplinary Care Management Plan did not include alternative or less restrictive measures to be attempted before resorting to restraints.	A 166		

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A 166	Continued From page 33 Hospital staff failed to incorporated less restrictive measures into Patient #16's plans of care.	A 166	**In response to A-169**	
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on staff interview, review of medical records, hospital policies and restraint log, it was determined the hospital failed to ensure restraint orders were not written as PRN orders for 2 of 2 patients (#16 and #38) for whom chemical and/or physical restraints were used. This had the potential to result in patients being restrained unnecessarily and compromise patient safety. The findings include: 1. Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10 after a self-reported polydrug ingestion. Patient #38 ' s record documented she was on a suicide watch and had a 1:1 sitter. The ED History and Physical dictated by the physician on 4/30/10 at 10:58 PM, stated that Patient #38 reported she had taken a half bottle of Extra Strength Tylenol, 2 full boxes of caffeine pills, and 2 full boxes of Benadryl. The ED History and Physical stated that Patient #38 remained quite alert without obvious symptoms in the ED. The ED History and Physical documented that Patient #38's blood Tylenol levels were less than 10. This was a normal result. The ED History and Physical stated the plan of treatment was to repeat Patient #38's Tylenol levels, and "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and	A 169	Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services Process Improvements: ✓ Draft of revised restraint policy, order sets, checklist, and audit process. Draft completed on June 29, 2010. ✓ Approval of revised Restraint policy and order sets, checklist and audit process by August 31, 2010. ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010. Action Plan Implementation: ✓ Management Council update regarding Restraint ordering and use. Held on June 17, 2010.	

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A 169	Continued From page 34 also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the calender year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 wanted her IV out and her saturation monitor off. The note further documented that Patient #38 stated, "It's my time to die. God told me it's my time. I had one thing to do, and I've done it." The note explained the physician came into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders, Restraint form dated 5/01/10 at 1:00 AM. The progress note side of the Restraint form title Clinical Justification for Restraints stated Patient #38 was pulling at her IV again and was expressing suicidal desire and will "sedate/restrain PRN." The section of "Demonstrates attempts to remove airway or other life saving devices" and "Violent/self-destructive behavior" were checked. The Doctor's Orders side of the Restraint form was checked to Initiate/Renew restraint use. This form was signed by the physician on 5/01/10 at	A 169	**In response to A-169 cont...** ✓ Medical Executive Committee education regarding restraint use. Held on June 22, 2010. ✓ Nursing Practice Council and Nursing Education Council education regarding restraint use. Held on July 6, 2010. ✓ Administrative Supervisor education regarding restraint use. Held on July 7, 2010. ✓ Management Council communication regarding the expectation that restraints are never to be ordered PRN. Sent July 8, 2010. QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metrics: 1) Percent of direct-care RN staff (excluding staff that are on leave) have reviewed the revised policy as indicated by a signed acknowledgement. 2) Percent compliance of required restraint documentation. This reporting process will end as of August 31, 2010.	

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A 169	Continued From page 35 1:00 AM. At 1:05 AM, the physician ordered Versed (a medication used to induce sleepiness and amnesia during surgery) 4-6 mg IV every 1 hour as needed for excessive agitation. The Vice President of Medical Affairs was interviewed on 6/09/10 starting at 1:15 PM. He reviewed Patient #38's record. He stated that it was unclear to him as to whether the Versed was ordered as a chemical restraint or used to treat the patient's anxiety. He stated the physician's dosing order was excessive in that it was ordered every hour, as needed. The hospital's policy titled Restraints, revised 12/09, did not identify PRN orders for restraints as unacceptable. The hospital's Director of Accreditation and Nursing Services was interviewed on 6/09/10 starting at 2:00 PM. She stated restraints were not to be ordered as PRN. The hospital failed to ensure restraint orders were not written as PRN orders. 2. Patient #16 was a 20-year-old female who was admitted on 4/23/10, after a self-reported overdose. Two pre-printed restraints forms, signed, dated and timed, were found within Patient #16's record. The first Progress Note/Doctors Orders, Restraints form, dated 4/25/10 at 4:10 PM, documented Patient #16 was unable to consistently follow/understand directions and was violent and/or had self-destructive behavior. In addition, there was handwritten documentation that the patient is agitated, considering leaving	A 169		

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A 169	Continued From page 36 AMA, and is not medically cleared to leave safely. On the Doctor's Orders side of the form, documented the patient had Nonviolent Behavior. Both the soft restraints and the one wrist and one ankle boxes were checked. There was no documentation in Patient #16's record that showed restraints were used that day. The second form, dated 4/26/10 at 12:00PM, documented Patient #16 was unable to consistently follow/understand directions and was violent and/or had self-destructive behavior. The Doctor's Orders side of the form documented Patient #16' s restraint order was renewed and the order expired in 4 hours. There was no handwritten documentation on the Progress Note side. The soft restraints, hard restraints, both wrists and both ankles boxes were all checked off. There was no nursing documentation that showed restraints were used that day. In an interview conducted on 6/09/10 starting at 1:40 PM, the hospital's Director of Accreditation and Nursing Services confirmed that restraints were not used 4/25/10 and 4/26/10 and restraints were not to be ordered as prn. The hospital failed to ensure restraint orders were not written as prn orders.	A 169		
A 178	482.13(e)(12) PATIENT RIGHTS: RESTRAINT OR SECLUSION When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical	A 178		

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A 178	Continued From page 37 safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1-hour after the initiation of the intervention -- o By a-- - Physician or other licensed independent practitioner; or - Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section. This STANDARD is not met as evidenced by: Based on staff interview and review of medical records and hospital policy, the hospital failed to ensure 1 of 1 patient (#38) reviewed who was chemically restrained for violent/self destructive behavior, received a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention. This resulted in the inability of the hospital to adequately assess patients for the causes of behaviors and treatment alternatives. The findings include: The hospital's Restraint Policy, last revised on 12/14/09, stated a LIP would do an in-person examination of patients within 1 hour after the initiation of the restraint. This policy was not followed. Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10 after a self-reported polydrug ingestion. Patient #38's record documented she was on a suicide watch and had a 1:1 sitter. The ED History and Physical dictated by a physician on 4/30/10 at 10:58 PM, stated Patient #38 reported she had taken a half bottle of Extra Strength Tylenol, 2 full boxes of caffeine pills, and 2 full boxes of Benadryl. The ED History and Physical stated that Patient #38	A 178	**In response to A-178** Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services Process Improvements: ✓ Draft of revised restraint policy, order sets, checklist, and audit process. Draft completed on June 29, 2010. ✓ Approval of revised Restraint policy and order sets, checklist and audit process. by August 31, 2010. ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010. Action Plan Implementation: ✓ Management Council update regarding Restraint ordering and use. Held on June 17, 2010.	

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A 178	Continued From page 38 remained quite alert without obvious symptoms in the ED. The ED History and Physical documented that Patient #38's blood Tylenol levels were less than 10. This was a normal result. The ED History and Physical stated the plan of treatment was to repeat Patient #38's Tylenol levels, and "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the calander year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 wanted her IV line out and her oxygen saturation monitor off. The note further documented that Patient #38 stated, "It's my time to die. God told me it's my time. I had one thing to do, and I've done it." The note explained that the physician had come into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders Restraint form, dated 5/01/10 at 1:00 AM. The progress note side of	A 178	**In response to A-178 cont...** ✓ Medical Executive Committee education regarding restraint use. Held on June 22, 2010. ✓ Nursing Practice Council and Nursing Education Council education regarding restraint use. Held on July 6, 2010. ✓ Administrative Supervisor education regarding restraint use. Held on July 7, 2010. QAPI Integration: ✓ Implementation of an audit tool and weekly reporting process for the following metrics: 1) Percent of direct-care RN staff (excluding staff that are on leave) that have reviewed the revised policy as indicated by a signed acknowledgement. 2) Percent compliance with required restraint documentation. This reporting process will end as of August 31, 2010.	

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	130006	A. BUILDING _____ B. WING _____	C 06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 178	Continued From page 39 the Restraint form title Clinical Justification for Restraints, stated Patient #38 was pulling at her IV line again and was expressing suicidal desire and will "sedate/restrain PRN." The section of "Demonstrates attempts to remove airway or other life saving devices" and "Violent/self-destructive behavior" were checked. The Doctor's Orders side of the Restraint form was checked to Initiate/Renew restraint use. This form was signed by the physician on 5/01/10 at 1:00 AM. At 1:05 AM, the physician ordered Versed (a medication used to induce sleepiness and amnesia during surgery) 4-6 mg IV every 1 hour as needed for excessive agitation. The 2010 Nursing Drug Handbook states Versed was a preoperative sedative and a medication for conscious sedation. The medication was listed as to induce sleepiness and amnesia. Versed was listed as to be given before and/or during surgeries to induce general anesthesia. The listed dosing recommendations for children ages 12 to 16 was to initially give no more than 2.5 mg IV. The 2010 Nursing Drug Handbook stated that Versed dosing could be increased to a total dose of up to 10 mg to reach the desired level of sedation. Patient #38's MAR documented she had received additional doses of Versed on 5/01/10 at 3:00 AM and at 6:28 AM. There was no documentation in Patient #38's medical record of a face-to-face evaluation by an LIP of Patient #38 within one hour of the administration of these chemical restraints. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM. She had reviewed Patient	A 178		

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A 178	Continued From page 40 #38's record. She indicated a face-to-face reassessment of Patient #38 was not completed within an hour of the adminstration of the medication. The hospital failed to Patient #38, who was chemically restrained, received a face-to-face evaluation by an appropriately qualified person within 1-hour after the initiation of the intervention.	A 178	**In response to A-186** Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services	
A 186	482.13(e)(16)(iii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of] Alternatives or other less restrictive interventions attempted (as applicable); This STANDARD is not met as evidenced by: Based on review of clinical records and interviews with staff, it was determined the hospital failed to ensure less restrictive interventions were attempted before the use of restraints for 2 of 2 patients (#16 and #38) reviewed who were chemically and/or physically restrained. The lack of alternatives and/or less restrictive interventions attempted before applying physical restraints resulted in the inability of the hospital to avoid the use of restraints when possible. The findings include: 1. Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10, after a self-reported polydrug ingestion. Patient #38's record documented she was on a suicide watch. The ED History and Physical dictated by the ED physician on 4/30/10 at 10:58 PM, stated that Patient #38 reported she had taken a half bottle of Extra Strength Tylenol, 2 full boxes of caffeine	A 186	Process Improvements: ✓ Draft of revised restraint policy, order sets, checklist, and audit process. Draft completed on June 29, 2010. ✓ Approval of revised Restraint policy and order sets, checklist and audit process. by August 31, 2010. ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010. Action Plan Implementation: ✓ Management Council update regarding Restraint ordering and use. Held on June 17, 2010.	

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A 186	Continued From page 41 pills, and 2 full boxes of Benadryl. The ED History and Physical stated that Patient #38 remained quite alert without obvious symptoms in the ED. The ED History and Physical documented Patient #38's blood Tylenol levels were less than 10. This was a normal result. The ED History and Physical stated the plan of treatment was to repeat Patient #38's Tylenol levels, and "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the calendar year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 wanted her IV line out and her oxygen saturation monitor off. The note further documented that Patient #38 stated, "It's my time to die. God told me it's my time. I had one thing to do, and I've done it." The note explained that the physician came into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes	A 186	**In response to A-186 cont...** ✓ Medical Executive Committee education regarding restraint use. Held on June 22, 2010. ✓ Nursing Practice Council and Nursing Education Council education regarding restraint use. Held on July 6, 2010. ✓ Administrative Supervisor education regarding restraint use. Held on July 7, 2010. QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metrics: 1) Percent of direct-care RN staff (excluding staff that are on leave) that have reviewed the revised policy as indicated by a signed acknowledgement. 2) Percent compliance with required restraint documentation. This reporting process will end as of August 31, 2010.	

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A 186	Continued From page 42 and Doctor's Orders, Restraint form dated 5/01/10 at 1:00 AM. The progress note side of the Restraint form title Clinical Justification for Restraints stated, Patient #38 was pulling at her IV line again and was expressing suicidal desire and will "sedate/restrain PRN." The section of "Demonstrates attempts to remove airway or other life saving devices" and "Violent/self-destructive behavior" were checked. The Doctor's Orders side of the Restraint form was checked to Initiate/Renew restraint use. This form was signed by the physician on 5/01/10 at 1:00 AM. At 1:05 AM, the physician ordered Versed (a medication used to induce sleepiness and amnesia during surgery) 4-6 mg IV every 1 hour as needed for excessive agitation. Patient #38's MAR documented she had received Versed on 5/01/10 at 3:00 AM and at 6:28 AM. The medical record did not indicate alternatives or other less restrictive interventions attempted before the administration of the versed. The record did not contain documentation that less restrictive interventions had been considered and ruled out, and the reasons why. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM. She had reviewed Patient #38's record. She stated Patient #38's record did not indicate why the Versed was given. She stated the Versed was ordered for anxiety and nursing staff would not document alternatives or other less restrictive interventions because the medication was not a restraint. 2. Patient #16 was a 20-year-old female admitted to the hospital on 4/23/10 after a self-reported drug ingestion.	A 186		

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A 186	Continued From page 43 Patient #16 ' s record documented she was on suicide watch and had a 1:1 sitter. Patient #16's record contained a nursing note, dated 4/23/10 at 10:39 PM, that stated Patient #16 was, "...very belligerent and fighting treatment and she was placed in soft restraints after which she became somnolent." Soft restraints are devices made of soft material that are designed to safely fit around the wrists, ankles, or chest of a patient to prevent patients from harming themselves or others. There was no documentation that alternative measures were offered or less restrictive interventions were attempted before placing Patient #16 in soft restraints. A nursing restraint flowsheet dated 4/23/10 at 10:10 PM, documented soft restraints were applied to both wrists and the ankles of Patient #16. Patient #16 was released from the restraints on 4/23/10 at 10:47 PM. There was no documentation that alternative measures were offered or less restrictive interventions were attempted before placing Patient #16 in soft restraints. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM. She reviewed Patient #16's record. She stated Patient #16's record did not document less restrictive measures were tried before using physical restraints. The hospital failed to ensure less restrictive interventions were attempted prior to the use of restraints.	A 186		
A 187	482.13(e)(16)(iv) PATIENT RIGHTS:	A 187		

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A 187	Continued From page 44 RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:] The patient's condition or symptom(s) that warranted the use of the restraint or seclusion. This STANDARD is not met as evidenced by: Based on review of clinical records and interviews with staff, it was determined the hospital failed to ensure that 1 of 1 patients, (#38), for whom chemical restraints were used, had documentation in the medical records of the conditions and/or symptoms that warranted the use of the restraints. The lack of documentation prevented the hospital from ensuring patients were physically/chemically restrained only when necessary to ensure their safety or that of others. The findings include: 1. Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10 after a self-reported polydrug ingestion. The ED History and Physical dictated by the physician on 4/30/10 at 10:58 PM, stated that Patient #38 reported she had taken a half bottle of Extra Strength Tylenol, 2 full boxes of caffeine pills, and 2 full boxes of Benadryl. The ED History and Physical stated that Patient #38 remained quite alert without obvious symptoms in the ED. The ED History and Physical stated that Patient #38's blood Tylenol levels were less than 10. This was a normal result. The ED History and Physical stated the planned treatment was to repeat Patient #38's Tylenol levels, and "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and also for hallucinations or alterations in mental status as a result of her	A 187	**In response to A-187** Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services Process Improvements: ✓ Draft of revised restraint policy, order sets, checklist, and audit process. Draft completed on June 29, 2010. ✓ Approval of revised Restraint policy and order sets, checklist and audit process. by August 31, 2010. ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010. Action Plan Implementation: ✓ Management Council update regarding Restraint ordering and use. Held on June 17, 2010.	

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A 187	Continued From page 45 Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, which stated Patient #38 wanted her IV line out and her oxygen saturation monitor off. The note further documented that Patient #38 stated, "It's my time to die. God told me it's my time. I had one thing to do, and I've done it." The note explained that the physician came into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders Restraint form, dated 5/01/10 at 1:00 AM. The progress note side of the Restraint form title Clinical Justification for Restraints stated Patient #38 was pulling at her IV line again and was expressing suicidal desire and will "sedate/restrain PRN." The section of "Demonstrates attempts to remove airway or other life saving devices" and "Violent/self-destructive behavior" were checked. The Doctor's Orders side of the Restraint form was checked to Initiate/Renew restraint use. This form was signed by the physician on 5/01/10 at	A 187	**In response to A-187 cont...** ✓ Medical Executive Committee education regarding restraint use. Held on June 22, 2010. ✓ Nursing Practice Council and Nursing Education Council education regarding restraint use. Held on July 6, 2010. ✓ Administrative Supervisor education regarding restraint use. Held on July 7, 2010. QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metrics: 1) Percent of direct-care RN staff (excluding staff that are on leave) that have reviewed the revised policy as indicated by a signed acknowledgement. 2) Percent compliance with required restraint documentation. This reporting process will end as of August 31, 2010.	

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A 187	Continued From page 46 1:00 AM. At 1:05 AM, the physician ordered Versed (a medication used to induce sleepiness and amnesia during surgery) 4-6 mg IV every 1 hour as needed for excessive agitation. Patient #38's MAR documented she received Versed on 5/01/10 at 3:00 AM and at 6:28 AM. The medical record did not indicate the conditions and/or symptoms that warranted the use of the chemical restraint. However, in a written statement, dated 6/11/10 by the nurse who administered the Versed, the nurse documented that the Versed was given to Patient #38 because, Patient #38 woke up several times during the night and requested "...more of 'that' medication." The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM. She reviewed Patient #38's record. She stated Patient #38's record did not include why the Versed was given and the conditions and/or symptoms that warranted the use of the chemical restraint. She stated the Versed was ordered for anxiety and so nursing staff did not document the conditions and/or symptoms that warranted the use of the medication. The hospital failed to ensure that staff documented in Patient #38's medical record the conditions and/or symptoms that warranted the use of the restraints.	A 187		
A 188	482.13(e)(16)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION [there must be documentation in the patient's medical record of the following:]	A 188		

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A 188	Continued From page 47 The patient's response to the intervention(s) used, including the rationale for continued use of the intervention. This STANDARD is not met as evidenced by: Based on review of clinical records and interviews with staff, it was determined the hospital failed to ensure that 1 of 1 patient, (#38), for whom chemical restraints was used, had documentation in her medical record of the response to the intervention. The lack of documentation prevented hospital staff in assessing the effects of the interventions. The findings include: 1. Patient #38 was a 13-year-old female admitted to the hospital on 4/30/10 after a self-reported polydrug ingestion. The ED History and Physical dictated on 4/30/10 at 10:58 PM, stated that Patient #38 reported she had taken a half bottle of Extra Strength Tylenol, 2 full boxes of caffeine pills, and 2 full boxes of benadryl. The ED History and Physical stated that Patient #38 remained quite alert without obvious symptoms in the ED. The ED History and Physical stated that Patient #38's blood Tylenol levels were less then 10. This was a normal result. The ED History and Physical documented the plan of treatment was to repeat Patient #38's Tylenol levels, and "...monitored continuously with cardiorespiratory monitoring because of her substantial caffeine ingestion by self report and also for hallucinations or alterations in mental status as a result of her Benadryl ingestion." Patient #38 was discharged on 5/01/10 at 2:35 PM. The physician's progress note dated 5/01/10 at 1:07 PM, stated Patient #38 had no tachycardia (increased heart rate), hypertension (high blood pressure), change in mental status, or increased	A 188	**In response to A-188** Action Plan Responsible Party: Bev Holland, MSN, RN, NE-BC, Administration St. Luke's Children's Hospital and Judy Jones, MSN, RN, NEA-BC, Administrator Women's Services Process Improvements: ✓ Draft of revised restraint policy, order sets, checklist, and audit process. Draft completed on June 29, 2010. ✓ Approval of revised Restraint policy and order sets, checklist and audit process. by August 31, 2010. ✓ The medical record for patients on restraints will be reviewed by the Nursing Administrative Supervisor or Charge Nurse. Initiated by August 31, 2010. Action Plan Implementation: ✓ Management Council update regarding Restraint ordering and use. Held on June 17, 2010.	

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A 188	Continued From page 48 Tylenol blood levels "to suggest claimed ingestion actually occurred." The hospital's restraint log for the year of 2010 identified Patient #38 as being restrained. Patient #38's record contained a nursing note, dated 5/01/10 at 12:40 AM, that stated Patient #38 wanted her IV out and her saturation monitor off. The note further documented that Patient #38 stated, "It's my time to die. God told me it's my time. I had one thing to do, and I've done it." The note explained that the physician had come into the room and spoke with Patient #38. The note stated the physician said to Patient #38 that "she had no choice but to get treated" and told her that they would restrain her if need be. Patient #38's record contained a Progress Notes and Doctor's Orders, Restraint form dated 5/01/10 at 1:00 AM. The progress note side of the Restraint formt title Clinical Justification for Restraints stated Patient #38 was pulling at her IV again and was expressing suicidal desire and will "sedate/restrain PRN." The section of "Demonstrates attempts to remove airway or other life saving devices" and "Violent/self-destructive behavior" were checked. The Doctor's Orders side of the Restraint form was checked to Initiate/Renew restraint use. This form was signed by the physician on 5/01/10 at 1:00 AM. At 1:05 AM, the physician ordered Versed (A medication used to induce sleepiness and amnesia during surgery) 4-6 mg IV every 1 hour as needed for excessive agitation. The 2010 Nursing Drug Handbook stated that Versed was a preoperative sedative and a medication for conscious sedation. The	A 188	**In response to A-188 cont...** ✓ Medical Executive Committee education regarding restraint use. Held on June 22, 2010. ✓ Nursing Practice Council and Nursing Education Council education regarding restraint use. Held on July 6, 2010. ✓ Administrative Supervisor education regarding restraint use. Held on July 7, 2010. QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metric: 1) Percent of direct-care RN staff (excluding staff that are on leave) have reviewed the revised policy as indicated by a signed acknowledgement. 2) Percent compliance with required restraint documentation. This reporting process will end as of August 31, 2010.	

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A 188	Continued From page 49 medication was listed as to induce sleepiness and amnesia. Versed was listed as to be given before and/or during surgeries to induce general anesthesia. The listed dosing recommendations for children ages 12 to 16 was to initially give no more than 2.5 mg IV. The 2010 Nursing Drug Handbook stated that Versed dosing could be increased up to a total dose of up to 10 mg to reach the desired level of sedation. Patient #38's MAR documented she had received Versed on 5/01/10 at 3:00 AM and at 6:28 AM. However, a written statement, dated 6/11/10, by the nurse who administered the Versed, documented that the Versed was given to Patient #38 because, Patient #38 woke up several times during the night and requested "...more of 'that' medication." The medical record did not indicate the response to the intervention. The hospital's Director of Accreditation and Nursing Operations was interviewed on 6/09/10 starting at 1:40 PM. She reviewed Patient #38's record. She stated that all PRN medications should have documentation of effectiveness whether it was a chemical restraint or not. She did not find documentation of the effectiveness of the 5/01/10 at 3:00 AM and 6:28 AM Versed. The hospital failed to ensure staff documented in Patient #38's medical record her response to the chemical restraint intervention.	A 188		
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. This STANDARD is not met as evidenced by:	A 396		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	130006	A. BUILDING _____ B. WING _____	C 06/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST LUKES REGIONAL MEDICAL CENTER	190 EAST BANNOCK STREET BOISE, ID 83712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 396	Continued From page 50 Based on staff interview and review of medical records and hospital policies, it was determined the hospital failed to ensure nursing plans of care were developed for 2 of 2 patients (#2 and #14) whose medical records were were reviewed for such plans. This resulted in a lack of direction to nursing staff caring for patients. The findings include: 1. Patient #2's medical record documented an 81 year old female who was admitted to the hospital on 3/04/10 and was discharged on 3/05/10. She presented to the emergency department on 3/04/10 at 9:45 PM. A History and Physicial, dictated at 12:43 AM on 3/05/10, stated Patient #2 had fallen and suffered a contusion of her forehead and laceration of her nose which required suturing. The report stated Patient #2 thought she had slipped and fallen. The report stated this was her third admission to the emergency department in 2 days. The report stated she had been seen first for a urinary tract infection and confusion. The report stated she had returned later and been treated for confusion related to dehydration. She was rehydrated and sent home again before returning a third time. The report stated "I get the impression that she is markedly depressed as well as somewhat paranoid and concerned about being here in the hospital." The report stated Patient #2 had a history of "...depression with possibly some psychotic features..." The report stated her affect was flat but she was oriented to person, place, and time. The report also stated Patient #2 did not appear to be in any distress but was tearful. The report stated the plan was to admit Patient #2 for hydration and "...possible consideration of a psychiatric evaluation and maybe transferred to [a geriatric psychiatric hospital] for medication	A 396	**In response to A-369** Action Plan Responsible Party: Cy Gearhard, MSN, RN, Administrator St. Luke's Heart Process Improvements: ✓ Focus on care plan documentation for patients placed on mental health holds, restraints for violent behavior, suicide precautions, and other behavioral health interventions by August 31, 2010. ✓ Approval and implementation of care plan documentation process by August 31, 2010. Action Plan Implementation: ✓ Implementation of the revised care plans will be facilitated through the Nursing Practice Council and Nursing Leadership Council. Implementation will be complete by August 31, 2010.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

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A 396	Continued From page 51 evaluation and adjustment." An Application of Commitment of the Mentally Ill, dated 3/05/10 at 1:31 PM, signed by the physician and filed with the court, stated Patient #2 was gravely disabled and needed to be placed on an involuntary hold. Patient #2's Interdisciplinary Care Management Plan, dated 3/04/10 and 3/05/10, did not contain a plan related to her behavior or psychological issues. The plan stated only that Patient #2 was a high fall risk and needed a bed alarm. No other plan directing care for Patient #2 was documented. Staff A, the nurse who cared for Patient #2 on 3/05/10, was interviewed on 6/10/10 at 9:20 AM. She reviewed the medical record and confirmed the lack of a plan of care for Patient #2. A nursing plan of care was not developed for Patient #2. 2. Patient #14's medical record documented a 69 year old male who was admitted to the hospital on 2/12/10 and was discharged on 2/15/10. Diagnoses included dementia, homosexual delusion, and diabetes. An involuntary hold was documented on 2/15/10. An Application of Commitment of the Mentally Ill, dated 2/15/10 at 5:30 PM, signed by the physician and filed with the court, stated Patient #14 needed to be placed on an involuntary hold. Nursing notes on 2/14/10, stated Patient #14 was sexually inappropriate with a male nurse and, on another occasion, had intrusively wandered into another patient's room.	A 396	**In response to A-369 cont...** QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metrics: 1) Percent compliance with a complete and accurate plan of care for each inpatient. This reporting process will end as of August 31, 2010.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 396	Continued From page 52 Patient #14's Interdisciplinary Care Management Plan, dated 2/13/10-2/15/10, did not mention his psychological status or direction to staff regarding inappropriate behaviors. The plan stated the patient was to have his blood glucose checked 4 times a day and he was allowed to be out of bed with assistance. Otherwise, no nursing plan of care was documented. Staff G, the RN assigned to Patient #14 on 2/15/10, was interviewed on 6/08/10 at 2:40 PM. She reviewed the medical record and confirmed the lack of a plan of care for Patient #14. A nursing plan of care was not developed for Patient #14. 3. Also refer to A166 as it relates to the failure of the hospital to ensure the use of restraints were incorporated into patients' plans of care.	A 396		

PRINTED: 06/16/2010
FORM APPROVED

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BB115	16.03.14.200.01 Governing Body and Administration 200. GOVERNING BODY AND ADMINISTRATION. There shall be an organized governing body, or equivalent, that has ultimate authority and responsibility for the operation of the hospital. (10-14-88) 01. Bylaws. The governing body shall adopt bylaws in accordance with Idaho Code, community responsibility, and identify the purposes of the hospital and which specify at least the following: (10-14-88) a. Membership of Governing Body, which consist of: (12-31-91) i. Basis of selecting members, term of office, and duties; and. (10-14-88) ii. Designation of officers, terms of office, and duties. (10-14-88) b. Meetings, (12-31-91) i. Specify frequency of meetings. (10-14-88) ii. Meet at regular intervals, and there is an attendance requirement. (10-14-88) iii. Minutes of all governing body meetings shall be maintained. (10-14-88) c. Committees, (12-31-91) i. The governing body officers shall appoint committees as appropriate for the size and scope of activities in the hospitals. (10-14-88)	BB115	**In response to BB115** Action Plan Responsible Party: Joanne Clavelle, MS, RN, NE-BC, FACHE ✓ A comprehensive plan of correction has been created to address all findings relative to A115. ✓ The plan of correction was reviewed and approved by the St. Luke's Quality Committee of the Board of Directors on July 6, 2010 and the full Board of Directors on July 13, 2010. ✓ The plan of correction was submitted to the Seattle CMS Regional Office on July 9, 2010. <u>Process Improvements, Action Plan Implementation, and QAPI Integration:</u> ✓ Process Improvements, Action Plan Implementation, and QAPI integration for each finding cited under A115 is described in the Plan of Correction submitted to the CMS Regional Office on July 9, 2010. A copy of this plan has been enclosed.	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE

STATE FORM 6899 7EK211 If continuation sheet 1 of

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BB115	Continued From page 1 ii. Minutes of all committee meetings shall be maintained, and reflect all pertinent business. (10-14-88) d. Medical Staff Appointments and Reappointments; (12-31-91) i. A formal written procedure shall be established for appointment to the medical staff. (10-14-88) ii. Medical staff appointments shall include an application for privileges, signature of applicant to abide by hospital bylaws, rules, and regulations, and delineation of privileges as recommended by the medical staff. The same procedure shall apply to nonphysician practitioners who are granted clinical privileges. (10-14-88) iii. The procedure for appointment and reappointment to the medical staff shall involve the administrator, medical staff, and the governing body. Reappointments shall be made at least biannually. (10-14-88) iv. The governing body bylaws shall approve medical staff authority to evaluate the professional competence of applicants, appointments and reappointments, curtailment of privileges, and delineation of privileges. (10-14-88) v. Applicants for appointment, reappointment or applicants denied to the medical staff privileges shall be notified in writing. (10-14-88) vi. There shall be a formal appeal and hearing mechanism adopted by the governing body for medical staff applicants who are denied privileges, or whose privileges are reduced.	BB115		

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BB115	Continued From page 2 (10-14-88) e. The bylaws shall provide a mechanism for adoption, and approval of the organization bylaws, rules and regulations of the medical staff. (10-14-88) f. The bylaws shall specify an appropriate and regular means of communication with the medical staff. (10-14-88) g. The bylaws shall specify departments to be established through the medical staff, if appropriate. (10-14-88) h. The bylaws shall specify that every patient be under the care of a physician licensed by the Idaho State Board of Medicine. (10-14-88) i. The bylaws shall specify that a physician be on duty or on call at all times. (10-14-88) j. The bylaws shall specify to whom responsibility for operations, maintenance, and hospital practices can be delegated and how accountability is established. (10-14-88) k. The governing body shall appoint a chief executive officer or administrator, and shall designate in writing who will be responsible for the operation of the hospital in the absence of the administrator. (10-14-88) l. Bylaws shall be dated and signed by the current governing body. (10-14-88) m. Patients being treated by nonphysician practitioners shall be under the general care of a physician.	BB115		

Bureau of Facility Standards

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BB115	Continued From page 3 (10-14-88) This Rule is not met as evidenced by: Refer to A115 as it relates to the Governing Body's failure to provide sufficient oversight and management necessary to ensure patients' rights were protected.	BB115	**In response to BB175** Action Plan Responsible Party: Cy Gearhard, MSN, RN, Administrator St. Luke's Heart Process Improvements: ✓ Focus on care plan documentation for patients placed on mental health holds, restraints for violent behavior, suicide precautions, and other behavioral health interventions by 8/31/10. ✓ Approval and implementation of care plan documentation process by 8/31/10. Action Plan Implementation: ✓ Implementation of the revised care plans will be facilitated through the Nursing Practice Council and Nursing Leadership Council. Implementation will be complete by 8/31/10. QAPI Integration: ✓ Implementation of an audit tool and reporting process for the following metrics: 1) Percent compliance with a complete and accurate plan of care for each inpatient. This reporting process will be completed as of 8/31/10.	
BB175	16.03.14.310.03 Patient Care Plans 03. Patient Care Plans. Individual patient care plans shall be developed, implemented and kept current for each inpatient. Each patient care plan shall include but is not limited to: (10-14-88) a. Nursing care treatments required by the patient; and (10-14-88) b. Medical treatment ordered for the patient; and (10-14-88) c. A plan devised to include both short-term and long-term goals; and (10-14-88) d. Patient and family teaching plan both for hospital stay and discharge; and (10-14-88) e. A description of socio-psychological needs of the patient and a plan to meet those needs. (10-14-88) This Rule is not met as evidenced by: Refer to A166 as it relates to the hospital's failure to incorporate restraint usage into patient care plans. Refer to A396 as it relates to the hospital's failure to keep current a nursing plan of care.	BB175		

St Luke's
Boise Regional
Medical Center
A St. Luke's Health System Hospital

190 East Bannock Street
Boise, Idaho 83712

stlukesonline.org

Gary L. Fletcher, CEO

July 9, 2010

Sent via facsimile to (206) 615-2088

Steven Chickering
Kate Mitchell
CMS – Survey and Certification
2201 Sixth Avenue, RX-48
Seattle, WA 98121

Re: CMS Certification Number: 13-0006

Dear Mr. Chickering and Ms. Mitchell:

This letter is in follow-up to your correspondence and Statement of Deficiencies dated June 29, 2010, advising us of your determination that St. Luke's Regional Medical Center is not in substantial compliance with the Medicare hospital Condition of Participation – Patient Rights (42 Code of Federal Regulations (CFR) § 482.13) based on a complaint investigation authorized by the Centers for Medicare and Medicaid Services (CMS) and completed by the Idaho Bureau of Facility Standards on June 10, 2010.

Enclosed you will find our Plan of Correction, on Form CMS-2567, describing procedures we have implemented and/or begun to implement to improve the processes cited as deficiencies, as well as our plans for ongoing monitoring and tracking to ensure that the plan is effective and that the specific deficiencies remain corrected. The plan demonstrates how we are incorporating our actions into our quality assessment and performance improvement program to prevent the likelihood that any similar event(s) will recur. Mrs. Joanne Clavelle, Vice President for Patient Care Services and Chief Nursing Officer, will be responsible for implementing our Plan of Correction.

The deficiencies cited were of great concern to St. Luke's. Immediately following our exit conference with the surveyors from the Idaho Bureau of Facility Standards, we began to develop and implement the enclosed Plan of Correction. Ms. Mitchell, thank you for allowing us to discuss our case with you on July 2, 2010. We appreciated the opportunity to describe the materials that we had already submitted to the state agency as well as to your office, which included our immediate plan of correction ("Response to Preliminary Findings from the Bureau of Facility Standards Complaint Investigation, June 7-10, 2010"). As you will see on the enclosed Plan of Correction we are promptly and diligently addressing the cited deficiencies.

Thank you for allowing us the opportunity to respond to your findings. If you have any questions or concerns, please feel free to contact me at (208) 381-3595.

Sincerely,

Christine Neuhoff
System General Counsel
General Counsel, Boise/Meridian

Enclosures

cc: Debby Ransom, Idaho Bureau of Facility Standards
Gary Fletcher, CEO, St. Luke's Boise/Meridian
Barton Hill, MD, VP Medical Affairs & CMO
Pam Bernard, COO, St. Luke's Meridian
Chris Roth, COO, St. Luke's Boise
Joanne Clavelle, VP Patient Care Services & CNO, St. Luke's Boise/Meridian

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
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July 20, 2010

Gary Fletcher
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **June 10, 2010**, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004507

Allegation #1: Hospital physicians change medications without consulting the patient.

Findings #1: An unannounced visit was made to the hospital 6/07/10 through 6/10/10. During the complaint investigation, surveyors reviewed policies, interviewed staff and patients, and reviewed 39 medical records.

Review of 39 records, documented that physicians did consult and document coordination of medication management with patients and/or family members where it was determined appropriate. For example, in the record of one patient, who presented to the Emergency Department on January 7, 2010, physician's notes documented on multiple occasions that the physician met and talked to the patient about her medication concerns. The physician resumed all of the patient's home medications, but the hospital did provide some formulary substitutes. The notes documented the patients concerns and the resolution of the concerns. The complainant's physician was interviewed. She stated the patient was concerned with

her medication management. The physician stated that she met with the patient on several occasions to discuss her concerns, as documented in her notes. The physician stated the patient was satisfied with the discussions.

Conclusion: Unsubstantiated: Lack of sufficient evidence

Allegation #2: Hospital physicians change patients medications without consulting the patients' primary physician.

Findings #2: The record of one patient, admitted to the hospital on January 7, 2010, showed the patient was admitted to the hospital only because a psychiatric bed was not available with in the community. The patient was placed on suicide watch and retained in the hospital until a bed became available at a psychiatric hospital. The physician who attended to the patient during her stay was interviewed. She stated the patient was medically stable, cognitive, and well versed in her medical conditions and medications. She stated that she reordered all of the patient's home medications with the exception of her long acting insulin. She stated because the patient was not eating at the time she felt it was not safe to reorder the long acting insulin until the patient was eating. At the point when the patient was eating her meals the long acting insulin was reordered. The record documented the patient's blood sugars were well controlled during her stay at the hospital. The physician stated she and the complainant reviewed, discussed, and made treatment decisions together. The physician stated the complainant was very involved and never requested her to consult another physician.

Additional patients' records reviewed, also showed appropriate coordination of patient care between physicians and patients.

Conclusion: Unsubstantiated: Lack of sufficient evidence

Allegation #3: Patients were being restrained without cause.

Findings #3: Medical records of 7 patients who were restrained in the year 2010 were reviewed.

One patient record reviewed documented that the patient had a history of seizures and, therefore, the physician wrote an order to have the patient placed on seizure precautions. Seizure precautions included placing the patient in a bed with all four side rails padded and in the upright position. There was no physician's order for restraints contained within the patient's medical record.

An interview was conducted with a hospitalist who took care of the patient. She

stated the patient was admitted for possible suicide attempt. She reported that the patient gave a medical history that included seizures. Due to the patient's medical history the patient was placed on seizure precautions. She said that seizure precautions meant close observation and all side rails padded to prevent injury and in the up position. She stated the patient was cognitive and her behavior was not violent or acting out and the patient did not have any physical deficits that would have prevented the patient from getting out of the bed. This was documented throughout the patient's medical record. The hospitalist confirmed that no orders were written for this patient to be restrained.

While the padded bed rails were used in an upright position, the patient had a staff member assigned to be with her at all time who could have put the rails down if requested to do so by the patient. This would allow the patient to get out of bed whenever she requested to do so. Therefore, in this situation, the bed rails were not considered a restraint.

However, the records of 2 of the 7 patients reviewed, showed physical and/or chemical restraints were used without evidence that less restrictive interventions had been considered and/or attempted prior to the use of the restraint. In addition, one patient's record did not include documentation of the patient's symptoms or behaviors that warranted the use of a chemical restraint. The record also showed the patient was given the medication used as the chemical restraint when the patient's documented behavior did not present a danger to the patient or others.

Therefore, based on information gathered related to the 2 patients noted above, the allegation is substantiated. Federal deficiencies were cited related to these findings.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #4: The hospital's housekeeping staff did not clean patients' rooms for up to 3 days, including urine of the floor.

Findings #4: One patient's complaint file contained an allegation that there was urine on the patient's floor and that housekeeping was not responsive in cleaning the patient's room in a timely manner.

Contained within the patient's complaint file was a hard copy of an email from the Clinical Supervisor of the Medical Floor to the Clinical Patient Relations Specialist. The email documented an investigation conducted by the Clinical Supervisor of the Medical Floor. The email documented that no one interviewed recalled urine on the

patient's floor.

An interview with the Clinical Supervisor of the Medical Floor was completed. He confirmed that he interviewed at least 15 staff members and no one saw any urine on the floor in the patient's room or heard the patient complain of urine being on the patient's floor.

Five staff members who worked on the patient's floor were interviewed. All five staff members remembered the patient and all five denied seeing urine on the patient's floor. All five staff members believed that housekeeping was in the patient's room every day. During tours of the facility it was noted that the facility and patient rooms were clean.

No information was found to show that housekeeping did not clean patients' rooms, including floors.

Conclusion: Unsubstanciated lack of sufficient evidence

Allegation #5: Patients on a suicide watch were not provided privacy and items, such as soap, towels, shower curtain, and telephone were moved out of their rooms.

Findings #5: The hospital did remove items from the rooms of patients on suicide watch that could be used by patients to harm themselves. Patients on suicide watch were also provided 1 to 1 staff supervision. The hospital's policies supported these practices. During interviews, staff reported they would provide privacy to the best of their ability but were also responsible for ensuring patients did not harm themselves.

It was determined the hospital appropriately balanced patient privacy with the need to keep patients safe from harm.

Conclusion: Unsubstanciated lack of sufficient evidence

Allegation #6: Patients on suicide watch were not allowed to make phone calls.

Findings #6: The hospital's Care of Patients with Threatened or Actual Suicide Attempt policy stated, staff would remove any items from the room that could potentially be used for self-harm. The policy referred to the hospital's Safety Check List. The hospital's Safety Checklist instructed staff to remove telephone cords from the room and store them in a locked cupboard. Neither the policy, nor the checklist, provided direction to staff as to how to accommodate patient's telephone needs.

One patient's record reviewed documented that the patient was admitted to the hospital for a possible suicide attempt and was placed on suicide watch. A nursing shift note stated the patient was talking on the phone and then the phone was taken away.

Staff were interviewed. One staff member that worked with the patient stated the patient did have a cell phone during most of her hospital stay. He stated that this was an oversight and when it was identified the phone was removed. He stated that patients who were on suicide watch were not allowed a telephone.

The hospital's Social Service Supervisor was interviewed. He stated that patients on suicide watch did not have a telephone in their room. He was unsure as to how staff were to allow patients to use the phone.

An RN was interviewed. She stated that patients on suicide watch did not have a telephone in their room and were not allowed to use a telephone.

Another RN was interviewed. She stated that patients on suicide watch did not have a telephone in their room and she did not know how patients were to use the phone.

Two other staff interviewed stated it was up to the nurse as to whether patients on suicide watch could use a telephone.

The hospital was cited for a deficiency at 42 CFR 482.13(b) for a failure to promote patient rights by defining its policies and practices and allowing patients on suicide watch to use a telephone.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #7: The hospital did not honor a patient's advanced directives.

Findings #7: One patient record reviewed documented that the patient was admitted to the hospital for a possible suicide attempt. The patient's record contained advanced directives in the form of a physician orders for scope of treatment (POST) and a do not resuscitate (DNR) document. A POST is a standardized physician order that directs the patient's life-sustaining treatment if the patient lacks capacity to make decisions about their care. Effective July 1, 2007, the POST form replaces the former DNR in documenting and directing the patient's treatment wishes concerning life-sustaining treatment.

The patient's record contained a history and physical signed and dated. Within the document was a statement, in bold font stating, "The patient does have a POST on record and on file, however, given the patient's current suicide attempt and mental duress we will hold her POST at this time, with reevaluation as the patient's mental duress improves."

An interview was conducted on 6/08/10 beginning at 1:30 PM, with a hospitalist who took care of the patient. She stated the patient was admitted for possible suicide attempt. She noted that the patient had a POST and a DNR in the medical record. However, the hospitalist knew that the POST and DNR were invalid due to the attempted suicide. She said she told the patient that information. The patient was not happy but stated that she felt the patient understood the rationale.

Under Idaho Code, Title 39, Chapter 45,Section 39-4512C, it states that, "Health care providers shall make reasonable efforts to inquire...not caused by...with no indication of homicide or suicide."

The hospital did not honor the patient's advanced directives as they are directed not to do so by Idaho law.

Conclusion: Unsubstantiated; Lack of sufficient evidence

Allegation #8: The hospital did not meet patient's speciality diets to include a dietary consult.

Findings #8: An unannounced complaint survey was conducted on 6/7/10 to 6/10/10. A review of medical records and a staff interview was conducted.

One patient record reviewed documented that the patient had a medical history of diabetes mellitus type II. The patient's record also contained documentation of a physician's order, dated 1/07/10 at 3:45 PM, for an 1800 calorie American Diabetes Association (ADA) diet. The record also documented her known food allergies.

The record further documented the patient's blood glucose levels were well within normal limits during the patient's hospitalization.

An interview was conducted with the Supervisor of Room Service. He stated that when patients have special dietary needs the staff make every effort possible to accommodate all patients' requests. Patients can have snacks throughout the day and are provided 3 meals a day. He stated that if patients are not happy with the food they are provided they have many other options to choose from. He also stated that

dietary consults were made upon an order from the physician. He confirmed that there was no dietary consult ordered for this patient.

An interview was conducted with a hospitalist who took care of the patient. She stated the patient was very familiar with the disease processes, to include her dietary needs. She did not feel there was any reason for a dietary consult and the patient never requested a dietary consult. She stated that the patient consumed proper amounts of food and her blood sugars were well controlled. This was supported by documentation in the patient's record.

There is no evidence that the hospital failed to meet the patient's special dietary needs of the patient. Therefore the allegation was unsubstantiated.

Conclusion: Unsubstantiated; Lack of sufficient evidence

Allegation #9: A patient was manhandled by a hospital staff member, leaving finger prints on the patient's shoulder.

Findings #9: The hospital's complaint log was reviewed for the year 2010. There was one assault allegation reported to the hospital during 2010. The allegation was from the patient included in the complaint file was the patient was assaulted during the patient's hospitalization. The allegation was not received until sometime after the patient was discharged.

Contained within the patient's complaint file was a hard copy of an email from the Clinical Supervisor of the Medical Floor to the Clinical Patient Relations Specialist. The email documented an investigation was conducted by the Clinical Supervisor of the Medical Floor. The email documented that no one interviewed recalled the patient complaining about an assault.

An interview with the Clinical Supervisor of the Medical Floor confirmed that he interviewed at least 15 staff members and no one heard the patient complaining of an assault. He stated that the allegation was turned over to the local law enforcement agency, who conducted their own investigation and found the allegation to be unsubstantiated.

Five staff members who worked with the patient, were interviewed. All five staff members remembered the patient and all five denied hearing the patient complain of an assault.

There is no evidence could be found that an assault took place.

Conclusion: Unsubstantiated; Lack of sufficient evidence

Allegation #10: The hospital did not provide a written response to patients' grievances.

Findings #10: A hospital policy, "Patient Concern, and Grievance Process," contained a section titled "Investigating and Responding." It stated an acknowledgement letter would be mailed to the patient/representative within 7 days of receipt of a formal complaint/grievance. The timeframe for review and investigation depended on the severity of the complaint/grievance. After the review was complete, the hospital would provide the patient with a written notice of its decision. Whenever possible, concerns and grievances would be resolved within 30 days of receipt. More complex grievances might require more than 30 days to reach resolution. The policy did not address the procedure to be taken if and when the hospital was not able to investigate or resolve the complaints within the time frames specified within the policy (whether they would contact the complainants to let them know of a delay).

A sample of ten grievances were reviewed. In four grievances, the hospital failed to respond to grievances consistent with hospital policies. There was a delay in sending acknowledgement letters to patients, investigating in a timely manner, and/or sending letters of resolution to patients or complainants. However, this was not true in the case of the patient identified in the complaint filed with the Bureau of Facility Standards.

During an interview with the Manager of Patient Relations stated it was their goal to resolve 90% of complaints and provide a written response within 30 days. In previous quarters they had met or exceeded this goal. She acknowledged that during the quarter beginning April 1, 2010, they had gotten behind, probably because they had been down one staff and another staff had been ill. She also stated it had been difficult at times to get responses from departments who were assigned to investigate complaints.

A hospital document written by the Manager of Patient Relations, titled Patient and Family Relations Quarterly Departmental Review 1st quarter and 2nd quarter FY 2010, dated 4/20/10, documented challenges facing the department. They included an increase in complaints, staff turnover of Patient & Family Relations staff, loss of one position, more complex complaints being receiving requiring more time, and the need for additional support (more Patient Relations Specialists, proactive program development, ongoing education throughout the organization).

The hospital was cited at 42 CFR 482.13(a)(2)(iii) for failing to investigate, resolve, and respond to complainants in writing within a timeframe consistent with hospital policy.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #11: The hospital did not release medical record to patients and/or their families when requested.

Findings #11: Ten requests for release of medical records were reviewed. Eight out of the ten requests were responded to in an appropriate manner, including that of the patient identified in the complaint.

However, two record requests involving a parent of two adoptive children were not fulfilled. The hospital documented receiving medical record requests on 3/27/09 and 2/18/10 from an adoptive parent of two children. An interview was conducted with the Boise Health Information Management (HIM)Manager and the Director of Nursing Administration. The Boise HIM Manager acknowledged the two unfulfilled requests for medical records from an adoptive parent.

The hospital was cited at 42CFR 482.13(d)(2) for failure to protect and promote adoptive parents' rights to access medical information on their adoptive children.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/srp

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IDAHO DEPARTMENT OF
HEALTH & WELFARE

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July 19, 2010

Gary Fletcher
St Lukes Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **June 10, 2010**, a complaint survey was conducted at St Lukes Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004526

Allegation #1: The hospital failed to release medical records to a legal guardian.

Findings #1: An unannounced visit was made to the hospital 6/07/10 through 6/10/10. During the complaint investigation, surveyors reviewed policies, interviewed staff and patients, and reviewed documentation related to requests for medical records involving 10 patients.

Review of hospital documentation indicated 8 out of 10 requests were released appropriately to patients or their legal guardians. However, the records related to 2 requests were inappropriately withheld. These requests involved a parent's request for release of medical records for two adopted daughters.

The hospital documented receiving medical record requests, on 3/27/09 and 2/18/10, from an adoptive parent. A computer-generated medical record form showed an "A" next to the patients' names, indicating the record request was still active or the request had not been finalized. A letter, dated 2/01/10, from a parent was attached to

one of the requests. In the letter, the parent stated she had made 5 prior requests for release of information in the previous 4 years, none of which had been fulfilled.

During an interview with the Boise Health Information Managment (HIM) Manager and the Director of Nursing Administration, record requests were discussed. The Boise HIM Manager acknowledged two unfulfilled requests (dated 3/27/09 and 2/18/10) for medical records from an adoptive parent for two daughters. She stated she realized in looking at the documentation that the hospital had not followed-up with the parent and should have done so and would do so. She also stated the first request had been shredded but should not have been shredded. Although the hospital would not have released the medical record information to the requestor based on the hospital's policy (referenced below), their department should have sent a response to the parent.

The hospital's policy, "Confidentiality and Security of Patient Information in HIM," stated that in order to protect all parties' identities, records on adopted infants would be released only by court order once the child had been discharged from the hospital and identifying information would be deleted unless the court specified otherwise.

The Boise HIM Manager was interviewed and her remarks were consistent with the above-referenced policy. She explained the hospital released information on adoptive children to the adoptive agency or an adoptive parent only by court order. When released, the information regarding the birth parents was "blacked out" to protect the privacy of the birth parents. When asked how the policy or practice was established, she explained it was based on information from the Idaho Hospital Association. Upon surveyor request, the Boise HIM Manager provided the reference from the Idaho Hospital Association.

The "Guidebook Issues in Health Care Management," published in 2008 by the Idaho Hospital Association had a section titled "Release of Information Regarding Adoptions." It recommended that each institution's policy stipulate that the adopting parents had the right to inspect the adoptee's medical records, consistent with state statues on minority. However, such inspection should not include the sealed birth certificate, nor identifying information on the child's birth parents. Thus, it was necessary for the institution to take measures to mask the identity of the birth parents.

During an interview surveyors asked the Boise HIM Manager how the hospital's policy to not release medical records to adoptive parents was derived from the reference provided (Guidebook Issues in Health Care Management). She stated she realized there was "a gap" and it would be necessary to revisit the policy and perhaps

seek legal council on the appropriateness of withholding medical records from adoptive parents.

The hospital was cited for a deficiency at 42 CFR 482.13(d)(2) for a failure to protect and promote adoptive parents' rights to access medical information on their adoptive children

Conclusion: Substantiated. Federal deficiencies related to the allegation are cited.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/srp

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July 15, 2010

Gary Fletcher
St Luke's Regional Medical Center
190 East Bannock Street
Boise, ID 83712

Provider #130006

Dear Mr. Fletcher:

On **June 10, 2010**, a complaint survey was conducted at St Luke's Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004633

Allegation: A patient's breast implant ruptured during a mammogram unit in 2007. Also, a breast sonogram report contained incorrect information.

Findings: An unannounced visit was made to the hospital on 6/07/10 to 6/10/10. Staff were interviewed. Ten medical records were reviewed of patients who had diagnostic breast procedures, including patients who had mammograms and/or sonograms.

Documentation for non-invasive outpatient procedures consisted only of radiology reports. Nurses and technicians did not document regarding the procedures or patients reaction to the procedures. This was consistent with community standards for Idaho. All patients had reports from a physician as to the findings of the tests.

One patient record documented a mammogram on 11/08/07. The radiology report, dated 11/08/07, stated the patient had a one centimeter hard mass in her right breast and had a right breast implant failure. This same patient had a sonogram of her left breast on 2/19/10. The radiology report stated the breast appeared intact and there were no suspicious lesions. A sonogram was not performed on the right breast. The report stated a bilateral diagnostic mammogram was recommended but the patient refused. There was no way to determine the accuracy of the reports.

The Manager of Breast Care Services was interviewed on 6/08/10 at 10:00 AM. She

stated the mobile mammography unit visited sites around the state. She stated staff at these site visits included a driver, a technician, and a nurse. She said there were no restrictions for mammograms for patients who had breast implants but they required eight radiologic views instead of four. She stated there had been no complications identified from mammograms in the past year. She also said the mammography and ultrasound departments participated in the hospital's quality improvement program.

No adverse reactions or complications were identified for patients who had diagnostic breast examinations. Reports appeared accurate.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

GARY GUILES
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

GG/srp